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ABSTRACT

This report details the development of a comprehensive and coordinated continuing education program of mental health training for professional and paraprofessional workers engaged in the delivery of human services to clients who live in a special catchment area formerly known as the Model Cities areas of Savannah, Georgia. The thrust of the training is, first, to help professional, paraprofessional and indigenous community caretakers recognize mental health problems which interfere with their relationships with their clients and intervene more directly and efficiently to alleviate some of these constraints; and second, to develop a training program which will be responsive to the changing needs of all participants. The training program is intended to be flexible enough to serve the needs of workers in diverse agencies and communities and to be applied across a broad spectrum of human service delivery systems. Included in the appendix are a number of inventories of mental illness attitudes and a locus of control and counselor evaluation scale with a statistical analysis of the responses of trainees. There are also sample forms used by trainees: a Client Social History Blank, Log Sheets and Post Session Evaluation Sheet. (Author/DOW)

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A Comprehensive Mental Health Program of Savannah, Georgia

June, 1977

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FINAL REPORT:

SAVANNAH MODEL CITIES COMMUNITY MENTAL HEALTH PROGRAM

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SAVANNAH MODEL CITIES COMMUNITY MENTAL HEALTH PROGRAM

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TABLE OF CONTENTS

LIST OF APPENDICES vii

LIST OF TABLES viii

PREFACE. xi

ACKNOWLEDGEMENTS xiii

CHAPTER I Introduction. 1

CHAPTER II Literature Review. 3

I. The Current Relationship between the Mental Health Professional and the Disadvantaged Client. 3

II. Problems with Hospitalization 6

III. Problems with the Disadvantaged Non-Hospitalized Client. 9

IV. Use of Some Traditional Mental Health Concepts in Training Community Workers. 11

CHAPTER III Relevance of Program to Field 17

CHAPTER IV Project Participation. 20

I. The Training Context: The Continuing Education Program of Savannah 21

II. Objectives of Neighborhood Continuing Education Program 21

III. Community Agencies and Staff Who Participated in the Training Project. 22

IV. Training Staff and Consultants for the Community Services Specialist Program 25

V. Overview of the Program Procedure 26

A. Introduction to the Training Phases 26

B. Training Phases 27

VI. Data Collection Procedure 38

VII. Description of Evaluation Materials 40

A. Attitude-Related Measures 40

B. Skills-Related Measures 43

C. Measures Related to Experience and Performance in the Work Situation 48

D. Post-Session Evaluations. 49

E. Other Measures. 49

CHAPTER V Results 50

CHAPTER VI Summary and Discussion 56

REFERENCES 69

APPENDICES 75

LIST OF APPENDICES

APPENDIX

A Community Mental Health Ideology Scale. 75

B Locus of Control Scale. 82

C Opinions About Mental Illness: Authoritarianism. 88

D Opinions About Mental Illness: Benevolence 96

E Opinions About Mental Illness: Mental Hygiene Ideology 104

F Opinions About Mental Illness: Social Restrictiveness. 112

G Opinions About Mental Illness: Interpersonal Etiology. 120

H Carkhuff's Index of Discrimination. 128

I Counseling Skills Evaluation. 140

J "Who Did What to Whom". 145

K Kagan Counselor Verbal Response Scale Rating Sheet. 147

L Post-Session Evaluation Form. 149

M Client Social History Blank 152

Symptom Checklist 153

Log-1 154

Log-2 156

Client Reply Blank. 158

N Background on Continuing Education Units. 159

The Community Services Specialist Certificate 164

O Special Workshop Themes Developed during and for Phase III of Training. 165

P Summary Tables of Statistical Analyses. 171

LIST OF TABLES

TABLE NUMBER PAGE

1. Participating Agencies and Demographic Information for Trainees. 24

2. Comparisons of Pre-training Scores of Experimental and Control Groups 172

3. Summary of F-Values for Locus of Control (A) X Pre-Post-Follow-up Trials (B) Analyses of Variance on Five Mental Health Attitude Measures. 173

4. Summary of F-Values for Locus of Control (A) X Pre-Post Trials (B) Analyses of Variance on Five Mental Health Attitude Measures. 174

5. Summary of F-Values for Locus of Control (A) X Pre-Post-Followup Trials (B) Analyses of Variance on Five Counselor Behaviors 175

6. Summary of F-Values of Locus of Control (A) X Pre-Post Trials (B) Analyses of Variance on Five Counselor Behaviors 176

7. Summary of F-Values for Authoritarianism (A) X Pre-Post-Folowup Trials (B) Analyses of Variance on Five Counselor Behaviors. 177

8. Summary of F-Values for Authoritarianism (A) X Pre-Post Trials (B) Analyses of Variance on Five Counselor Behaviors. 178

9. Summary of F-Values for Benevolence (A) X Pre-Post-Followup Trials (B) Analyses of Variance on Five Counselor Behaviors. 179

10. Summary of F-Values for Benevolence (A) X Pre-Post Trials (B) Analyses of Variance on Five Counselor Behaviors 180

11. Summary of F-Values for Mental Hygiene Ideology (A) X Pre-Post-Followup Trials (B) Analyses of Variance on Five Counselor Behaviors. 181

LIST OF TABLES—(Continued)

TABLE NUMBER PAGE

12. Summary of F-Values for Mental Hygiene Ideology (A) X Pre-Post Trials (B) Analyses of Variance on Five Counselor Behaviors. 182

13. Summary of F-Values for Interpersonal Etiology (A) X Pre-Post-Followup Trials (B) Analyses of Variance on Five Counselor Behaviors 183

14. Summary of F-Values for Interpersonal Etiology (A) Pre-Post Trials (B) Analyses of Variance on Five Counselor Behaviors 184

15. Summary of F-Values for Community Mental Health Ideology Scale (A) X Pre-Post-Followup Trials (B) Analyses of Variance on Five Counselor Behaviors 185

16. Summary of F-Values for Community Mental Health Ideology Scale (A) X Pre-Post Trials (B) Analyses of Variance on Five Counselor Behaviors. 186

PREFACE

The staff of human services delivery systems in their daily activities continually come into contact with large numbers of people with minor adjustment problems associated with personal, social, or financial concerns. Others are much more severe such as chronic alcoholism, drug addiction or disabling psychological syndromes. All too often, problems of adjustment prevent the person from seeking human services, compromise the effectiveness of the services given, or underlie the need for community services. In addition, research results show that individuals with these kinds of problems, especially among the disadvantaged, do not make use of existing mental health services. Rather, the guidance and mental health centers around the country have been utilized by the more educated and affluent, and therefore, deal primarily with the problems which are characteristic of this group. The disadvantaged who do have contact with these facilities perhaps do so by necessity rather than choice because their problems continue to progress to the point where intensive treatment including hospitalization is required. Such delay of help giving is costly with respect to human suffering, productivity and treatment.

The purpose of the project that follows was to develop a continuing education program of mental health training for workers who provide ancillary services to the disadvantaged. The intention of training was to increase the community workers' general effectiveness by integrating knowledge of mental health concepts, preventive strategies and intervention skills with their previously acquired expertise in the delivery of human services.

The dedication, enthusiasm and openness of the individuals who participated in the training program are primary factors responsible for its success. The cooperation of trainees and agencies with respect to the training program itself was admirable and no better could be sought. The cooperation with respect to the evaluative facets of the program was varying. Nevertheless, in our judgment, the problems that arose are of the type that we wrestled with and future investigators most certainly need to find better solutions for. The results of the evaluation support the success of training with a diverse array of agencies and staffs with practical implications for other communities.

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CHAPTER I

INTRODUCTION

The purpose of the present project was to develop a comprehensive and coordinated continuing education program of mental health training for professional and paraprofessional workers engaged in the delivery of human services to clients who live in a special cachment area formerly known as the Model Cities areas in Savannah, Georgia. The Model Cities areas comprise approximately 18,200 residents of which 90% are Blacks. They are serviced by about 415 professional, technical and kindred personnel employed by numerous community services agencies of which many participated in this program. The intention of training was to increase the workers' general effectiveness by integrating knowledge of mental health concepts, preventive strategies, and intervention skills with their previously acquired expertise in the delivery of human services. Demographic information in the field of mental health care adds credence to the planning, and consequently need identification of the program and location. Numerous surveys have found that rates of admission to mental health centers and other facilities of disturbed groups are:

1. Twice as high in urban areas as compared to rural areas;
2. Twice as high for blacks in all diagnostic categories as compared to whites;
3. Higher for unemployed as compared to the employed;
4. Higher for unstable families as compared to more stable families;
5. Higher for lower socio-economic groups as compared to the more affluent; and
6. Higher in disadvantaged neighborhoods as compared to more stable ones.

A fundamental assumption underlying the proposed training is that mental health problems, in the context of the delivery of human services, can best be viewed as maladaptive living patterns which interfere with the client's fullest use of a broad range of currently available human services. It is assumed that such living patterns are caused by and reflect a complex interaction of constitutional, intra- and inter-personal, economic, legal, and educational factors and, as such, rarely present themselves as independent entities to be treated by workers trained specifically in the mental health field. Sarason and Ganzer (1968) put it well:

> " . . . the line between social pathology and individual pathology is so exceedingly vague that the jobs of the clinician, researcher, educator, administrator, supervisor, community organizer, and consultant can overlap greatly . . . especially in prevention and positive mental health." (page 6)

Central to this viewpoint is the fact that there exist in the Savannah Model Cities area professional, paraprofessional, and indigenous personnel trained to meet a broad range of client needs. Nevertheless, the mental health problems of a significant proportion of their clients directly interfere with client use of the services intended to meet those needs. In other words, in this context mental health problems endanger the worker-client relationship since it is only within the context of such a human relationship that human services can be implemented. Such problems range from chronic psychosis and paranoia to more moderate, but all too often, appropriate feelings of distrust and despair commonly found among Model Cities' citizens. What is needed then are skills on the part of human services workers to help alleviate the resistance of clients so that the fullest use of the available resources can be made by them.

The thrust of the training was two-fold: (1) to help professional, paraprofessional, and indigenous community caretakers recognize mental health problems which interfere with their relationships with their clients and intervene more directly and efficiently to alleviate some of these constraints; and (2) to develop a training program which, through continuous client, worker, and independent observer feedback and evaluation, will be responsive to the changing needs of all participants. The intention was to develop a training program which was flexible enough to serve the needs of workers in diverse agencies and communities and which could be applied across a broad spectrum of human services delivery systems. The training was not for mental health workers nor was it intended to develop a separate cadre of such workers. Likewise, the program was not designed to replace the available mental health programs, but rather to supplement and enhance them. In doing so, the mental health professional should have more time to devote to problems of a more severe nature.

The program represented a two-year pilot project with the Neighborhood Continuing Education Program of Savannah serving as the coordinating unit and four institutions of higher education, in concert with the Chatham County Mental Health Center and other cooperating mental health and other service agencies in the Savannah area, were linked to the interests, needs, and problems of the disadvantaged and others in the Model Cities areas. Thus, the training program attempted to provide a model for utilizing the resources of a community to develop viable continuing education for human services workers

CHAPTER II

LITERATURE REVIEW

I. The Current Relationship Between the Mental Health Professional and the Disadvantaged Client

Despite his expertise and concern the mental health professional very often has not been able to find a consistent way to provide for the delivery of human services to the educationally, culturally, and financially disadvantaged (Matarazzo, 1971). For example, Ryan (1969) found that in the greater Boston metropolitan area, which is the birthplace of the community mental health movement, as many people were counseled by clergymen as by psychiatrists and that social caseworkers (not professional social workers), settlement house staff, and non-psychiatric physicians were by far the major client care-givers. A national survey (Gurin, Veroff, and Feld, 1960) showed that 42% of Americans who seek help for personal problems turn to the clergy. Cumming and Cumming (1965) found that up to one-half of the calls coming to an urban police department involved family or other complaints of a personal or social nature. One difficulty has been that the mental health professional, unwittingly, often has not been available, either geographically or socially, to handle crisis. Particularly among the poor, often only crises move persons to seek outside help and, in such situations, the helper must be able to provide immediate strategies for coping with an all too concrete reality. Cowen (1967) refers to the notion of the "maximally impactful intervention." His point is that the best time to intervene is in a crisis, and furthermore, that when under stress people respond more effectively to the familiar community worker than the mental health professional who most often would be a stranger and, on that basis, alone likely to increase the stress. Along these lines, in a simulated situation, a comparison was made of the responses of psychologists, social workers and indigenous workers to a number of carefully chosen case histories. The comparison revealed that the indigenous workers, insofar as their as if behavior was concerned, focused more on immediate rather than long-term consequences of the problem; were less verbal but offered more participatory help; and indicated that they would make more return visits to uncooperative clients than either the psychologists or social workers.

Much has been made of the current and projected manpower shortages in psychology, psychiatry, social work, and nursing (Albee, 1959, 1968a; Arnhuff, Rubinstein, and Speisman, 1969). However, these shortages may obscure a more basic lack in the delivery system of human services. Bettis and Roberts (1969) appear to have demonstrated, for example, that in one state 50% of all hospitalized patients although requiring care, could be treated more effectively by neighborhood counseling, foster care, half-way houses, and nursing care if the resources -- *most non-professional* (italics ours) -- were available.

When mental health professionals are directly involved in the delivery of services, the nature of their services often has not been understood or appreciated by recipients. Brooks and Dean (1960) found that recently released patients were more likely to specify hospital attendants and work supervisors as having been helpful rather than doctors or other professionals. Indeed, Zaslove, Ungerleider and Fuller (1966) found that 45% of a sample of 68 patients totally omitted any mention of their physicians or individual therapists as having been helpful. More pertinent to the presently proposed project, a sample of 74 patients were asked just prior to hospital release who had been most and least helpful. Although the more intelligent and sophisticated patients chose psychologists and psychiatrists as the most helpful and aides and other patients as least helpful, the less intelligent and sophisticated patients made exactly the opposite choices. The latter patients most likely are similar to a number of human services recipients in the Model Cities program. In a most interesting study, Zolik and Stosky (1966) queried 103 college undergraduates 15 months after their having taken an introductory psychology course which emphasized emotional disorders, mental health professionals, and the importance of early and proper referral. Under conditions of non-ego involvement (the patient was described as not a close friend or relative) the students were more likely to refer to a professional. However under conditions of ego involvement, the students themselves preferred to intervene first.

II. Problems With Hospitalization

A substantial number of recipients of human services in a Model Cities cachment include former hospital patients requiring after-care and follow-up services. Two factors are clear regarding these clients: (1) a large number need never have been hospitalized if appropriately trained non-professionals are available prior to hospitalization; and (2) hospitalization itself is, on the whole, a demeaning, destructive experience which should be avoided if at all possible. Regarding the latter point, studies have found that, for many patients, hospitalization results in a decrease in cognitive functioning (O'Connell, 1969) and positive pro-social behavior (Ullmann, 1967) and has an adverse effect on self-concept (Hartlage and Hale, 1968). In addition, hospitalization has been shown to be related to an increase in disordered behavior (Honigfeld and Gillis, 1967) and dependence (Fontana and Corey, 1970), as well as a reduction in knowledge of outside events and a desire to leave the hospital (Wing, 1961). This latter finding, of particular economical as well as mental health relevance, has been corroborated indirectly by Mendel (1966) who found a positive relationship between length of initial hospitalization and length or re-hospitalization if required.

The fact that the initial hospitalization of mental patients often results in a desire not to leave the hospital and to longer re-hospitalization has been related to two factors: (1) those patients who prefer hospitalization, while having unfavorable attitudes toward the hospital and staff, hold even more unfavorable attitudes toward the community from which they came (Fontana and Corey, 1970; Gordon and Groth, 1961; Linn, 1969); and (2) often the most important variable in the decision to hospitalize clients was whether they had been hospitalized (Mendel and Rappaport, 1969). Indeed, Freeman and Simmons (1963) found that families and relatives who had hospitalized a patient once showed reduced tolerance to future bizarre behavior. The importance of these findings to the present project is that it appears reasonable to expect that the existence of community human services workers who are adept at and willing to deal with potential as well as formerly hospitalized patients would reduce the need for initial as well as re-hospitalization.

Clearly, hospitalization of any member is an event to be avoided in the life of the community if at all possible. Much of the negative effect of hospitalization can be traced to factors intrinsic to insitutionalization; e.g., an overworked staff, arbitrary regimentation, and an often necessarily cold, impersonal stance toward the patient. In addition, however, there is evidence to suggest that the mental health professional who most often comes from a middle class background, holds biases most often unintentional, toward the lower class person who makes up the bulk of hospitalized mental patients. For example, Hilles (1969) found that among young hospitalized patients, labeling of certain illegal behaviors was a function of patient social class. Repeated theft was seen as "sick" for upper class patients but "antisocial" for lower class patients. The importance of differential labeling as a function of social class rather than actual patient behavior lies in that such labeling leads to different kinds of treatment much of which may be irrelevant to the behavior it is meant to ameliorate since it is based on social class rather than behavior. However, in a unique study which examined the interaction of therapist and patient social class, Kandel (1966) found that whether lower class hospitalized patients received psychotherapy was a function of the paternal social class of the resident to whose ward the patient was assigned. This study will be referred to in a later section of this review.

Hospitalization should be avoided and often can be avoided if appropriately trained community care-givers are available. Reports based on the Boston Hospital Home Treatment Program have been particularly encouraging. Friedman, Becker, and Weiner (1964) found that specially trained registered nurses supervised by psychiatrists or social workers prevented hospitalization in 43% of those cases referred to a Public Health Agency specifically for hospitalization. In another study, Meyer, Schiff, and Becker (1967) found that, with professional consultation, human service agency workers averted hospitalization in 64% of those cases referred by the family and 72% of those cases referred by other community agents. However, the latter authors also found that the program was less effective with those cases who had been hospitalized and released before the program began.

Despite the obvious advantages which accrue to potential patients if they are not hospitalized and the economic benefits for the patient, his family, and the community as a whole, there are certain difficulties which must be acknowledged. For example, a distinct burden is placed upon the patient's family. At least initially, it may be applied easier for a family to have a member who is engaging in bizarre and/or destructive behavior removed than be forced to cope with him on a daily basis while he is receiving out-patient help. Grad and Sainsbury (1966) observed a cachment area in which a community mental health center recently opened but in which a more conservative hospital already had been operative for some time. They found that the immediate family burden was relieved by referral to the community mental health center which led to increased family tensions which, in turn, led to the need for increased psychological and social support. Consequently, although one of the indirect goals of the training project was to reduce the rate of psychiatric hospitilization within the Savannah Model Cities area; it was realized that the human services workers in the area would need training in order to offer appropriate additional support to the family of a person receiving out-patient as opposed to in-patient treatment.

There is substantial evidence that the majority of hospitalized patients who are returned to the community do not use after-care facilities (Beard, Pitt, Fisher, and Goertzel, 1963). Wolkon and Tanaka (1966) and Vitale (1962), in two separate studies, found that only 33% and 10% of the patients they surveyed, respectively, were brought into the after-care system. As a result approximately 37% of released patients return to the hospital within one year and 56% to do so within three years (Johnson and McNeal, 1965). After reviewing a number of studies, Silverstein (1968) has argued that up to 88% of hospital re-admissions are a function of failure to use after-care services and Wolkon and Tanaka (1965) have suggested that this failure is largely a function of the fact that mental health professionals from middle and upper social class backgrounds have not been able to attract released hospital patients, the majority of whom are from the low strata of society.

Despite the deleterious effects of hospitalization, the majority of which are results of "institutionalism" rather than the well-meaning help of the professional staff, there is evidence that patients' positive attitudes toward mental hospitals relate directly to treatment responses while in the hospital. It seems reasonable to expect that if hospitalization becomes necessary (and hospitalization cannot always be avoided) human service workers, known and trusted by the prospective patient, would be more effective in properly preparing that patient for hospitalization than an unknown, necessarily somewhat removed professional. Furthermore, since human services workers very often belong to the same community as the persons served, they not only are in a position to make hospitalization a beneficial experience but they also would be available to patients upon return to the community.

III. Problems with the Disadvantaged Non-Hospitalized Client

The plight of the hospitalized mental patient prior to, during, and after hospitalization has been emphasized to point up some of the difficulties in the majority of presently functioning human services system. It need only be added that the majority of such patients come from the lower socio-economic background than if the client was middle class. Hunt (1962) presented data from a child guidance clinic which suggest that the process is more complex. Lower class clients were less likely than middle class clients to keep an intake appointment but if the appointment was kept, the lower class client significantly more often than the middle class client was referred elsewhere for services other than psycho-therapy which in that clinic was the preferred mode of treatment. These studies are representative of a number of studies which support the generalization that low income clients choose to enter the helping relationship less often than middle and upper class clients, but if they do, predominantly middle class professionals are more likely to reject them than middle and upper class clients.

More recent data, while corroborating that lower class clients often are rejected for psychotherapy, which is considered to be the treatment of choice by most mental health professionals, also suggest that rejection may be a function of the interaction between therapist and client social class. Mitchell and Namenek (1970) queried 97 experienced psychologists and psychiatrists engaged in the private and public practice of psychotherapy. They found that middle and upper class therapists reported as typical significantly more middle and upper class clients. However, therapists from a lower middle and lower class background reported seeing significantly more lower class clients. These out-patient data are similar to Kandel's (1966) study of hospital psychotherapy. To repeat, she found that, on wards supervised by psychiatric residents from middle and upper class backgrounds, middle and upper class patients were much more likely to receive psychotherapy than lower class patients. However, on wards supervised by residents from lower middle and lower class backgrounds the likelihood of receiving psychotherapy was not related to patient social class. The data offered by Kandel (1966) and Mitchell and Namenek (1970) are particularly germaine to understanding the relationship between the typical mental health professional and the typical resident of a Model Cities program. In both studies there was a sufficiently large sample of therapists whose background was lower middle and lower class so that the effect of both therapist and client social class backgrounds could be investigated. These studies indicate that mental health professionals, per se, do not reject the poor. Instead, the more generic variable underlying the relative inability of the typical mental health professional to provide human services to the poor is social class dissimilarity. Unfortunately, most mental health professionals come from middle or upper class backgrounds.

It is apparent, then, that the mental health professional has not been particularly successful in meeting the mental health needs of the poor, and furthermore, that the poor have not sought out the mental health professional. Consequently, the present and projected shortage of mental health professionals is of little importance to the typical Model Cities resident since, even if there were a sufficient number of such professionals, they and the poor simply do not get together. At present and in the foreseeable future there exists and will continue to exist a marked "culture barrier" between the typical mental health professional and the poor (Kessel and McBreaty, 1967).

IV. Use of Some Traditional Mental Health Concepts in Training Community Workers

Of equal importance to the delivery of human services to the poor is the growing realization, stated earlier, that the mental health problems of the poor are not independent of everyday living, but rather are woven into the fabric of all human services including health, education, welfare, recreation, and legal aid. If mental health professionals have not been able to provide to the poor those services which they were trained to provide, it is even more likely that they would not be able to provide services for which they are not trained to people against whom they harbor biases, however unintentional. It would appear far more economical and effective to offer workers presently engaged in the delivery of human services those additional skills necessary to deal with mental health problems in the context of the delivery of the full gamut of human services. In other words, it is likely (and studies will be cited below to support this point) that those workers who can recognize and deal most effectively with many mental health problems which prove to be impediments to the Model Cities client's fullest participation in his community most likely are those human service workers presently working and often living in the model cities cachment (Matarazzo, 1971; McGee, 1965). Indeed, the delivery of a number of purely mental health services including counseling and psychotherapy already have been turned over to workers other than mental health professionals (Cates, 1970; Ryan, 1969; Zolik and Stotsky, 1966).

Such "abdication" should not be a source of concern, however. In a study of clients' perceptions of "good" and "bad" psychotherapists in which the majority of clients were middle class, Strupp, Fox, and Lessler (1960) found that the "good" therapist was most often described as attentive, genuine, adept in small talk, never critical, often giving simple advice and reassurance. As far as middle class psychotherapy clients are concerned, then the "good" therapist does not engage in highly complex, seemingly mystical behavior. Instead, those behaviors which are recalled as most effective are behaviors which derive from common sense notions about interpersonal relationships and which should be easily learned by human service workers of varying educational and cultural backgrounds responsible for clients of equally diverse backgrounds. It should be emphasized that the purpose of the training project was not to produce psychotherapists or even more broadly conceived mental health workers. On the other hand, some of these techniques and goals originally developed within a psychotherapeutic context were generalized to the present training project. Two contemporary observers of the psychotherapeutic endeavor, who also have pioneered training programs for indigenous community workers, have proposed that psychotherapy might best be viewed as education in interpersonal living, with therapists as teachers of interpersonal skills (Rioch, 1970; Carkhuff, 1971). Consequently, one aspect of the training program focused on the development of interpersonal skills which should enhance the relationships between human services workers and their clients. In addition, such skills could then be extended to clients to enhance their interpersonal relationships by helping trainees see themselves not only as caretakers, but also as models for their clients. Indeed, Howard and Orlinsky (1972), after reviewing the major psychotherapy studies published from January 1969 to March 1971, observe that "the available evidence concerning therapeutic process . . . suggests to us . . . that psychotherapies of all types involve the symbolic communication--through language, gestures, and actions that the patient understands and believes--of benevolent care from a person or agency of respected influence (italics theirs)." Certainly, nothing more nor less should be asked of a teacher, public health nurse, welfare, or model cities worker.

It may appear reasonable to doubt that human services workers in Model Cities programs, for whom the present training program is geared, can readily learn mental health concepts and their effective use to improve worker-client relationships and ameliorate some of those mental health problems which keep the client from using the full gamut of human services. However, there are a number of studies which demonstrate conclusively that, with minimal training, such workers can deal effectively with mild to severe mental health problems in the context of the delivery of human services and that, in dealing with the poor, they often can do so more effectively than the mental health professional. A review of these studies suggests that such success most often is a function of worker-client similarity along a number of dimensions including race, ethnic background, education, place of residence, and values in living.

Four studies (Carkhuff and Truax, 1965a; 1965b; Poser, 1966; Hetherington and Rappaport, 1967) have served as "psychological landmarks" providing the impetus for and prototypes of a number of training programs which have attempted to generalize from more traditional mental health concepts and which involve personnel with little or no previous mental health training. Carkhuff and Truax (1965a) compared five lay counselors with 15 highly experienced psychotherapists. After only 100 hours of training the five lay counselors (primarily hospital attendants) closely approximated the levels of accurate empathy and warmth offered by the experienced psychotherapists.

These counselor behaviors have been shown to be highly related to improvement among a variety of client populations including hospitalized schizophrenics, juvenile delinquents, and outpatients (Truax and Mitchell, 1971). In a second study (Carkhuff and Truax, 1965b) the same five lay counselors, with supervision, offered three months of group counseling to chronic, severely disturbed, hospitalized patients. Only one patient so treated was judged to have deteriorated over the three-month period while 38 were judged improved. In contrast, of a control group of patients who received the usual hospital treatment, 19 were rated as improved, while 12 were rated as deteriorated. In the experimental and control groups, approximately the same number, 35 and 38, respectively, were judged as having neither improved nor deteriorated.

Hetherington and Rappaport (1967) had six volunteer middle-aged women meet with six hospitalized patients at a time once a week for 12 weeks. The focus was on reorientation to common social and community activities including eating out and bus and shopping trips. Of 249 patients selected for the project, 235 patients completed the program and 146 left the hospital. The average age of the selected patients was 48 years; they had prior to initiation of the program, been hospitalized for an average of 13 years. Of note, early in the program the authors dispensed with formal training because it was found to impede the volunteers' spontaneity and effectiveness and increase their anxiety. This latter finding will be returned to in a latter section since there is conflicting evidence which suggests that on-going suspension and training is necessary in such volunteer programs.

Finally, Poser (1966) found that a program using undergraduate coeds as companions to chronic, severely disturbed, hospitalized schizophrenics was more successful, as measured across a large number of variables, than professionals offering traditional individual or group psychotherapy.

Although all four studies dealt with hospitalized patients, the studies are relevant to the training of human services workers in Model Cities programs for a number of reasons. First, they demonstrate that non-mental health professionals with little or no training can be as helpful as or more helpful than professional therapists. Second, these findings were based on patients who, on the average, are more severely disturbed than the typical Model Cities recipient of the usual range of human services. Finally, many of the skills used by the non-professionals in these studies are typical of but not limited to those that taught in the present project.

Turning now to those studies which focus on workers and services more pertinent to the present project, Covner (1969) found that volunteer alcoholism counselors after only eight weeks of training were as effective as mental health professionals in getting alcoholic clients to stop drinking and become involved in treatment. The volunteers were also effective in offering education and pre-treatment counseling. Covner also compared those volunteers considered more and those volunteers considered less successful. Using the California Psychological Inventory, he found that the successful counselors scored higher on "sensitivity to others," "self-control," and "socialization."

Gartner (1969) has reported the results of two programs in Oklahoma and Los Angeles. In the former, seven indigenous workers were able to bring an average of 2,000 persons a month to an immunization clinic in contrast to three public health nurses who average only 200 persons a month. In the latter program, Black and Chicano youth were judged more effective as nutrition counselors than second year medical students. Criteria were amount of knowledge and use made of specific nutrition information by lower class clients. It is likely that, in both projects, the racial and ethnic similarity of the non-professionals accounted, at least in part, for their greater success.

A number of studies have focused on increasing the worker's ability to listen and be empathic. It should be noted again that empathy has been found to be related strongly to counseling success (Truax and Mitchell, 1971). Parenthetically, it should be noted that in Covner's (1969) study of volunteer alcoholism counselors, successful counselors were found to be more sensitive to others than counselors judged to be less successful. Using simple training procedures and focusing exclusively on this one interpersonal skill, Carkhuff (1969) found non-professionals were able to improve their ability to discriminate and communicate feelings; and Collingwood (1969) found the same even when the training took place with large groups. Furthermore, again focusing on learning to be more empathic Carkhuff and Bierman (1970) improved the interpersonal functioning of parents of emotionally disturbed children, which improvement, in turn, was of direct benefit to the children; and Anromico, Fidler, Guerney, and Guerney (1967), Guerney, Stover, and Andromico (1967), and Stover and Guerney (1967) were successful in teaching mothers to effect significant improvement in the interpersonal functioning of their own children.

On a broader scale, Libo and Griffith (1966) have described a long-term community consultant approach in which mental health professionals served as consultants to indigenous workers throughout the State of New Mexico. The project has served as a model for a number of consultant-worker projects. Non-professionals, with minimal levels of training but continuous consultation, helped alleviate drinking problems among Navajo Indians who had come to the attention of law enforcement agencies. A second project was successful in screening second-grade students for psychiatric advisory and referral services.

A major study comparing the home care treatments of recently hospitalized and ambulatory schizophrenics has been reported by Pasamanick, Scarpitti, and Dinitz (1967). They found that the use of medication plus systematic public health nursing care resulted in 77% of previously hospitalized patients remaining out of the hospital for at least three months. A control group which did not receive these combined services averaged 83 days in the hospital over a three-month period of the experiment. Similar studies using minimally trained community personnel from professions other than mental health as well as lower class, indigenous workers have proven successful with such diverse client populations as emotionally disturbed chidren (Hobbs, 1966); chronic, "backward" geriatric patients (Donahue, Gottesman, and Coons, 1968); and "hard-core" juvenile delinquents (MacLennan, Klein, Pearl, and Fishman, 1966; and Fishman, 1968).

CHAPTER III

RELEVANCE OF PROGRAM TO FIELD

These trainees, because of their daily activities in such areas as education, health, religion, home and family management, and the like, continually come into contact with large numbers of people with an array of problems and needs. Some of these problems could be considered minor adjustment difficulties associated with personal, social, or financial concerns. Others are much more severe such as chronic alcoholism, drug addiction, or disabling psychological syndromes including psychotic behavior.

Research results show that individuals with these kinds of problems, especially among the disadvantaged, do not take advantage of existing services for a variety of reasons. Rather, the guidance and mental health centers around the country have been utilized by the more educated and affluent, and therefore deal primarily with the problems which are characteristic of these individuals. Consequently, the disadvantaged have had little contact with established mental health agencies. Those that have had contact perhaps have done so by necessity rather than by choice because their problems progressed to the point where intensive care and treatment was essentially difficult and costly.

A major task of the program was to multiply the impact of the mental health professional and the trainees on the problems in the community. A major purpose of the program was to increase the sensitivity of trainees to nuances of their own and others' behavior, rather than teach highly specialized mental health techniques. Cowen (1967) indicated that if training is too technique-oriented, it would merely create workers in the image of the mental health professional. On the other hand, if the orientation is personal and motivational, the training will allow for systematic reflection about relevant experiences and build confidence in a supportive situation.

While agreeing in general with Cowen (1967) it also seems relevant that the science of psychology has made enormous progress in the last five years and that we can provide specific information and skills without losing sight of the fact that our goal is to increase the general effectiveness of human services workers in ways which will allow them to serve the needs of a widely divergent clientele in a fully autonomous fashion.

Based upon the present level of research, that people learn best by doing, the trainee must experience that something works and how it works in a learning situation conducive to trial-and-error learning, or behavior shaping, before he can successfully apply his new learning. Consequently, although some time was given to presenting information in didactic form, most of the training was experiential and was in-service rather than pre-service. In other words, the bulk of training consisted of dyadic and group interaction and role-playing, and was based on the trainees' on-going caseload.

The objectives that were proposed for this project are designated as general objectives and specific objectives. Although these goals are both product and process-oriented, they are categorized in a way that shows them as objectives for overall continuing education for participant needs.

General Objectives

1. Identify the available human and material resources of cooperating mental health agencies and services.
2. Strengthen the amount of involvement and degree of cooperation and coordination among the agencies currently offering mental health services in the program area.
3. Provide training for human services personnel in specific problem areas.
4. Develop and test this program as a training model for adaptation by other communities with similar problems and needs.

Specific Objectives

1. Learn principles of human behavior and techniques of behavioral change developed for this educational program and based on an operant model.
2. Identify community health agencies and their services in order to make appropriate referrals.

3. Learn and be able to demonstrate certain communication skills for more effective performance of services.
4. Recognize deviant patterns of behavior and distinguish among those which should be dealt with or referred to other agencies.
5. Apply acquired skills and knowledge to problems encountered in actual situations.

In general, then, the training program should help the trainee to distinguish more sharply and reliably between adaptive and maladaptive behaviors as well as help him decide when the latter can be handled by himself or requires referral to a mental health professional. The training should provide specific techniques that permit the trainee to enhance his relationships with his more "difficult" clients, by altering their behavior and by utilizing more consistent and specific schedules of positive reinforcement.

At the outset of each training group and throughout the duration of training, the trainees, with the help of the trainers, specified the problems they faced in working with their clients and the kinds of skills they felt would help them deal with these problems. The identification of such problems assured that training was based on actual needs of the trainees.

CHAPTER IV

PROJECT PARTICIPATION

This chapter, entitled "Project Participation," provides background information about the training context, the cooperating community agencies and their staff who participated as trainees and the training staff of the Community Services Specialist program. This chapter also provides an overview of the training program, the data collection procedures and a description of evaluation materials.

I. The Training Context: The Continuing Education Program of Savannah

The Neighborhood Continuing Education Program of Savannah is located in the central section of the Model Cities area and contains a stable composition of blacks and whites. There are numerous facilities including five schools and four civic centers which can be used to conduct educational programs.

The program is currently operated administratively by the University of Georgia through the Center for Continuing Education. However, programs are sponsored cooperatively by Georgia Southern College, Savannah State College, Armstrong College, and the University of Georgia. The faculty and administration of these institutions of higher education are vitally interested and committed to the development and implementation of an innovative educational program for the Model Cities neighborhood residents.

A professional adult educator directs the program with offices in the Model Cities district. A major responsibility of the director is to pinpoint the residents' educational needs and marshal the suitable educational resources from all participating institutions and agencies to meet them.

II. Objectives of Neighborhood Continuing Education Program

The purpose of establishing the Model Cities neighborhood program was twofold: (1) to establish a location in the Model Cities area whereby educational experiences could be designed and offered to the people in the neighborhood area, (2) to serve as a seed bed for educational research which can provide clues to certain basic questions about deprived persons in an urban setting. It is anticipated that research findings as a result of this program can be applied to other urban areas on a much larger scale.

Specifically, some of the major program and educational objectives that serve to guide in the development and implementation of the educational program are as follows:

Program Objectives:

1. To establish an organizational structure which will link relevant human material resources of the four sponsoring institutions to the educational needs of people in the program area.
2. To learn what process will most effectively allow for developing educational programs to meet the problems and needs of people in the program area, establish priorities, and select the most appropriate course(s) of action by involving the local persons with the educators.
3. To conduct educational programs and services that will meet the problems and needs identified.
4. To seek active involvement of the institutions of higher education and relevant agencies in the formulation, implementation, and evaluation of educational programs.
5. To create a laboratory setting wherein research can be conducted which can lead to the development of more appropriate and effective adult educational programs for the area citizens.

Educational Objectives:

1. To help adults become better consumers, workers, parents, and citizens as well as participants in the political processes.
2. To help adults accept education as a way of life, so they can understand their problems, changing environment and make a more successful adaption to it.
3. To help adults acquire a minimum level of education necessary to find a job.
4. To help adults improve their job performance and consequently improve their economic status.

III. Community Agencies and Staff Who Participated in the Training Project

During the more than eighteen months that preceded the submission of the proposal for the present training project, meetings were held in Savannah with agency heads, supervisors and potential participants to determine the specific needs of trainees as well as the needs of the people who would be affected by this program. At that time, the heads of agencies through supportive letters indicated that the program as envisioned would complement their on-going programs and would be enhanced by them. These agencies and their personnel also expressed their concern for the mental health problems of the disadvantaged population of

Savannah's Model Cities as well as their support of the program with their cooperation and resources. Contacts with agency heads were maintained throughout the course of the training project to provide them with information about the progress of the program, to secure their feedback about the impact of the program on the needs of their staff and to arrange the scheduling of training sessions.

During the two years of the project, eighty-one persons were recruited from community agencies and programs for participation in the training project. Table 1 presents a list of participating agencies as well as descriptive information about the trainees. As can be seen from the table, the trainees for the most part were black females, had a high school or college degree, were in the 21 to 55 age range, and were in direct service roles. Upon successful completion of the three phases of the program, trainees were awarded a certificate of training as a Community Services Specialist by the University of Georgia Center for Continuing Education. In addition, a permanent transcript was prepared for each trainee which recorded the continuing education units (CEU's) earned by the trainee in relation to hours of participation. The total number of CEUs that a trainee could earn was, therefore, contingent upon the number of contact hours of participation. (See Appendix N.)

Not all of the eighty-one trainees completed the entire three-phase sequence of training and/or participated in all of the data collection sessions. A new class, representing ten percent of the trainees, began the month preceding the end of the project so that insufficient data existed for their inclusion in the statistical analyses. The participants from one agency, or about seven percent of the trainee sample withdrew prematurely from the program when they were unable to qualify the CEUs earned as credit toward an academic degree. However, the factor contributing most to instability within the sample of trainees was occupational or residential transitions. Seventeen percent of the trainees moved from

TABLE 1

Participating Agencies and Demographic Information

Agencies

Georgia Department of Human Resources
West Side Health Center Outreach Program
Industrialization Opportunities Center
Savannah Homemaker's Service
Vista Volunteers
EOA Community Development
Visiting Teacher's Program
Savannah Clergy

Staff Position	
Managerial Level (Supervisor/Director/Program Planner)	11%
Direct Services Level	89%
Sex of Trainees	
Females	85%
Males	15%
Race of Trainees	
Blacks	89%
Whites	11%
Age of Trainees	
Less than 21 years old	0%
21 to 35 years	53%
36 to 55 years	43%
56 and over	4%
Education	
Less than High School	13%
Completed High School	45%
College Work or Completed College	38%
Graduate Work or Completed Graduate Studies	4%

the Savannah area or changed jobs, many taking positions in the private sector. The bulk of these departures from training occurred either during Phase III of the program or especially before the follow-up evaluation.

IV. Training Staff and Consultants for the Community Services Specialist Program

Responsibility for the development of the specific content areas of the training program was shared between the co-principal investigators and the appointed staff of the Chatham County Southside Mental Health Center. On some occasions, consultants were recruited to provide training in special topic areas. In addition, other mental health workers assisted in the implementation of training. The staff of the training program were as follows:

Chatham County Mental Health Center

Dan Johnston, Ph.D.	Clinical Psychologist
Orin Sadler, Ph.D.	Clinical Psychologist
Adrain Robinson	Training Director

Consultants

Henry E. Adams, Ph.D. University of Georgia	Clinical Psychologist
Karen S. Calhoun, Ph.D. University of Georgia	Clinical Psychologist
Dean Kilpatrick, Ph.D. University of South Carolina Medical School	Clinical Psychologist

Psychological Assistants

John Robert Entrekin
University of Georgia

Alma Dell Smith
University of South Carolina Medical School

Joan Robison
South Carolina VAH

Terry Seyden
Southside Mental Health Center

Billy Howe
Southside Mental Health Center

Toby Firedman
Southside Mental Health Center

Mike Graham
Southside Mental Health Center

V. Overview of the Program Procedure

A. Introduction to the Training Phase

The project consisted of three separate and distinct phases of training which coincided with trainees' inservice activities rather than pre-service preparation. Altogether, five groups of trainees participated in the project. Each group of trainees was composed of 8 to 18 members representing a variety of agencies. Each group began the program as a unit and continued working together within that unit until the completion of the program at which time members of the unit were awarded their certificates as Community Services Specialists.

Phase I consisted of a twelve hour conference period largely but not exclusively didactic in nature, which covered principles of normal human behavior, identification and causes of maladaptive behavior, a practical guide to communication effectiveness, and an overview of behavioral change. During Phase I, the focus was on providing information that was relevant to all trainees regardless of their educational level, agency affiliation or formal duties.

In Phase II, the trainees often were divided into smaller groups to practice and receive feedback on targeted interactional skills. In order that the training experiences offered were specific and relevant, the context of practice was defined by the needs of clients served by trainees and the service delivery function of trainees. In this way, training was derived from experience rather than instruction. The primary goal of Phase II was to allow the trainees simulated conditions to perform those skills conceptualized in Phase I. The emphasis was on performance, immediate feedback, reinforcement and modeling of basic skills.

Phase III involved a considerably longer period of time than the other phases, during which the trainees had an opportunity to practice, develop and integrate the information and skills of Phases I and II. The fundamental difference between Phases II and III was that in Phase II, the trainee learned the basic skills and was given an opportunity to practice them in simulated conditions until a minimal level of mastery was reached so that he (she) could begin to use these skills with clients. In Phase III, the trainee was offered a stable, ongoing, supportive relationship with the trainers and other project staff over a long period of time, in order to integrate these new skills in life, experiencing all of the variations, the advantages and disadvantages, failures and successes. In this way, the skills conceptualized in Phase II could become a personal part of the trainee's service-role repertoire.

B. Training Phases.

Phase I: Conference for Community Services Specialists

1. Overview of the Project

Phase I began by introducing trainees to the history, general purpose and objectives of the project. Particular emphasis was given to defining the role of trainees in the program and to the valuable contribution they could make through their input in helping to shape the content of training to fit their service-role needs as well as the needs of their clients. Background information on the fundamental concept of the program was presented and discussed with the trainees. This included the following themes:

a) the circumstances that bring clients to seek help from community agencies often include or produce psychological stress;

b) it is well established that individuals served by community service agencies under utilize mental health resources for psychological adjustment problems;

c) as a frontline force, trainees would be in a position to assist clients with minor adjustment problems within their range of skills or to help those clients with more severe disturbances obtain appropriate professional attention;

d) psychological intervention early in their client's distress should prevent the development of more severe disturbance; and

e) psychological skills should complement current service functions to increase efficiency and effectiveness of service delivery.

2. Introduction to Normal-Abnormal Behavior

This facet of Phase I focused on the definition and identification of maladaptive behaviors. The presentation was geared to a practical observable level rather than an abstract consideration of mental illness syndromes. To increase the dialogue between trainers and trainees, the latter were asked and encouraged to highlight the presentation with experiences from their own case contacts. As far as possible these experiences were then employed to develop the points of presentation. The themes of this section of Phase I included:

a) popular misconceptions and myths which the general public hold about mental illness or maladaptive behavior that stigmatize the psychologically troubled individual and that often times complicate behavior change efforts;

b) identification of adaptive and maladaptive behavior with respect to the personal and social consequences of behaviors;

c) the specification and description of psychological problems in behavioral terms, that is emotional, cognitive, interactional, motor habits, sexual, alcohol and drug abuse, etc.;

d) individual and environmental factors that give rise to and maintain maladaptive behavior; and

e) guidelines for distinquishing minor adjustment problems and more severe psychological disturbances.

3. Principles of Human Behavior and Behavior Change

This topic area provided the trainees with basic concepts of social learning and the principles of modeling, reinforcement, and contingency learning. Following the presentation and discussion, the film entitled "Who did What to Whom" (1972) was shown. This film shows a series of vignettes involving the interactions of persons in different roles (e.g., employer and employee). The trainees each of the interactions one at a time applying the information on learning principles They recorded their evaluation on an answer sheet (see Appendix J) and each vignette was discussed immediately following their written response.

4. Introduction to Behavior Change Methods

This section presented the basic methodology involved in applying the learning principles covered in the previous section to the client's problems. In addition, the trainees were informed on how to systematically observe and record behavior. They were encouraged to make systematic observations at the onset and during their contacts with clients in order to get an appreciation for the effectiveness of the service efforts. Examples from the case loads of trainees were employed to demonstrate methodologies of behavior change programs.

Phase II: Workshop Series

During this phase of training participants received eighteen contact hours of instruction involving communications skills for interviewing and counseling, crisis intervention, and establishing goals and roles in the counseling relationship. This phase of training provided specific, identified problems allowing more in-depth coverage of applied subject matter. This phase of the program was not designed to enable trainees to develop a high degree to proficiency in skills. Rather, trainees were provided in-depth exposure of skills with a minimal amount of practice.

A distinction should be made between performance and practice. There is ample evidence which suggests that the mechanics of a behavioral skill can be learned quickly under simulated conditions (Mitchell, Bozarth, Rubin, and Wyrich, 1971; Rappaport, Gross, a[illegible]er, 1972). Considerably more time needs to be given to the practice of that skill so that the trainee understands the behavior in all of its nuances, the conditions under which the skill should or should not be employed, as well as the means to appropriately moderate its frequency and/or intensity. Thus, Phase II primarily simulated conditions for learning, although examples from the trainees' actual caseload often provided the content. Emphasis of training methods was on small group interaction, role-playing, immediate feedback as a source of both instruction and motivation, and use of the trainer as both a reinforcing agent and model.

A particular training strategy used in the present project was "micro-teaching" (Borg, Kallenback, Morris, and Fribel, 1969). Briefly, any complex skill, whether it is teaching, communication, or counseling, is broken down into simple sub-skills. Each sub-skill is modeled by the trainers, and then practiced in one-to-one or role-played interactions as well as in group situations until each trainee has had the opportunity to perform and be the recipient of one or more sub-skills. A portion of the skills are added, over time, and practiced until eventually the trainees are asked to perform the complex skill until criterion levels are reached.

A number of writers engaged in training non-professionals have suggested that although the non-professional's enthusiasm seems to be a major reason for his success (Cowen, 1976), it wanes over time without on-going supervision and support (Vesprani, 1969). Thus, Eisdorfer and Golann (1969) have suggested several training principles which were followed in the present project.

1. emphases were placed upon role clarification, particularly limitation of responsibility;
2. trainees were told that the training was experimental;
3. trainees had a stable, on-going relationship with the project's trainers;
4. group solidarity and support were encouraged; and

5. trainees were given specific tasks and goals and on-th-job training as soon as possible; learning of vague concepts was limited.

Training also took into account initial trainee anxiety about acquiring new tasks and goals, particularly regarding clients whose behavior they feel often is bizarre and whom they may have referred elsewhere in the past. In addition, to the use of micro-teaching to learn identification, communication, and behavior modification skills, and utilization of the training principles suggested by Eisdorfer and Golann, the current training project emphasized role-playing as a way of handling initial trainee anxiety and resistance. For example, trainers and trainees took turns assuming each other's role and then assuming the roles of the trainee and counselor. The strategy, based on Kelly's (1955) fixed role therapy for adults, allowed the trainers to function as models and reinforcing agents and was expected to lead to desensitization of trainees' role and task anxiety. Indeed, there is evidence that role-playing can serve to reduce anxiety (Lazarus, 1966). And DeWolfe (1967), in an interesting demonstration of the impact of modeling procedures, found that student nurses who were initially afraid of TB patients become less afraid merely as a result of working with fearless, experienced nurses.

1. Communication Skills for Interviewing and Counseling

The communications skills emphasized in the program came from a number of sources but, in particular, are based on the work of Truax and Carkhuff (1967), Carkhuff and Berenson (1967), Carkhuff (1972) and Gordon (1970). The latter focused on "active listening" as an effective technique for eliciting client verbalizations which do not appear under everyday conditions. Briefly, "active listening" includes such worker behavior as: (1) listening to the clients for a fixed period of time before making any response; (2) checking with the client by paraphrasing or actually repeating what the client has said; (3) moving beyond the surface content of what the client has said by paraphrasing the client but including previously unstated feelings and reasons for the client's statements.

Carkhuff's (1972) helping model is more than a communications model since he is interested ultimately in behavior change. We have borrowed from the communications portion, but believe that behavior change can be effected more efficiently by using principles of modeling and reinforcement or contingency learning. Briefly, Carkhuff sees the helper as first attending and then being responsive, that is, simply responding to the client in an understanding manner elicits client self-exploration. When the helper is responsive, not only in response to the client's verbalizations but in initiating responsiveness based on his own experience, he furthers his client's understanding of his behavior.

The introduction of communication skills to the trainees employed Kagan (1972) program of counseling skills training. This involves a coordinated presentation of counseling skills through cassette audiotape, film strip and a 16 mm audiovisual film. Each counseling skill is defined, described, modeled within the context of an interview or counseling situation portrayed in brief filmed vignettes. These vignettes involved a wide array of problems and a variety of counselor service roles.

Once basic skills were learned, the task was to integrate them into a smooth flowing counseling style. This integration was accomplished through extensive role playing. The trainees worked in small groups by participating in experiential exercises utilizing each of the skills. One trainee would enact the role of a client with a specific problem. Another trainee would role play the counselor, whose task was to counsel with the "client," by using the targeted counseling skills. Role-playing was followed by evaluation feedback and discussion.

2. Application of Skills to Psychological Crisis

Often times, the clients served by the participating agencies seek help for problems whose onset is abrupt rather than incidious. On such occasions it is likely that the manner of onset precipitates a psychological crisis. This facet of Phase II is based on a crisis intervention model and program prepared by Johnston (1972) which applies the counseling skills of the previous section to the special situation of crisis intervention. A micro-counseling approach also was employed to crisis management skills.

The trainees first were introduced to a theory of crisis development to provide a rationale for their interventions. Briefly, the model of crisis development states that a crisis state occurs because of a loss of equilibrium and a continuing inability on the part of the client to restore equilibrium due to an imbalance in cognitive, effective, or behavioral skills. Implicit in this model is the process of crisis resolution. If an individual enters crisis because of an imbalance in the three levels, then resolution is advanced by aiding the individual to restore balance to these levels, i.e., moving him from unrealistic perception to realistic perception, from a state of no emotional support to a state of receiving emotional support, and from having no appropriate coping skills to possession of needed skills.

Once the detailed presentation of the crisis model was made, a five-stage intervention process was taught. Briefly, this five-step process involves: (a) establish emotional contact with the client; (b) clarification of the client's current situation, problems, stress, emotional state, etc.; (c) mobilization of immediate resources; (d) setting of short-term goals; (e) termination and referral as appropriate. The remainder of this section involved the integration of counseling skills into the five-stage crisis management process. Here counseling skills that are appropriate to each of the five stages of crisis intervention were practiced in an experiential, role-playing context like that described in the previous section.

3. Factors Affecting the Process and Outcome of Service Delivery

During this section of Phase II, a number of the problems that arise in the service delivery and counseling process were discussed and integrated with the earlier sections. These discussions centered on the following themes.

a) Successive structuring. Lennard and Bernstein (1960) found that much of what counselor's and clients talk about early in counseling involves who is to do what, when, and for what reasons. In this way, counselor and client gradually develop congruent expectancies about their counseling roles, methods, and goals of their contacts together. Rotter (1954) referred to this process as successive structuring and encouraged counselors to set aside time at the beginning and at points during counseling to discuss and review these matters with the client. Using examples generated in the previous sections, trainees were asked to talk over the facets of behavior change roles and methods in simple, informal terms rather than technical terms.

b) Help-giving, self-help and helplessness roles. This theme explored the relationship between counselor and client and the occasional problem that counselors unintentionally foster or maintain helplessness on the part of their clients. For example, counselors who expect, exclusively focus on, and reinforce problem admitting or complaints of their clients may support a self-concept of helplessness and a helpless role on the part of the client. Likewise, service workers who overlook or underestimate the strengths and personal resources of clients may over-deliver on help-giving and thereby encourage help-needing rather than the self-help behaviors of clients. The helplessness of clients may also be the product of either their own self-expectations of failure or the expectations of failure communicated by family members, spouses or friends.

c) Goal-setting. This theme began with the assertion that the problems of clients are usually complex or multiple, and consequently require multiple interventions or complex counseling strategies. Therefore, it becomes necessary to establish priorities for which behaviors are targeted for change first and those to come later. Using caseloads from their service experience, trainees delineated the needs of a particular client and established tentative approaches for change. Trainees then established hierarchies of change, taking into consideration the immediacy of needs for the client as well as short-term and long range behavior change goals.

A second feature of goal setting that was explored involved establishing a series of functionally related steps toward the targeted area of change. The thrust of this theme was to increase the probability that clients would experience success at each step along the way toward change. As clients experience success at each step, their confidence in themselves is likely to increase and their expectancy about the overall success of counseling is likely to increase. Conversely, when very large changes are asked of clients this often elicits their expectations of failure and often their reluctance to cooperate with the service worker. Since the probability of failure is much higher, this would only serve to increase the client's sense of frustration and helplessness.

A third feature of goal-setting involved the anticipation of environmental factors that potentially might delay or interfere with progress toward behavior change through counseling. Often times, problems of this sort can be circumvented when counselor and client anticipate these stumbling blocks during the planning stage of counseling and behavior change and permit solutions to be incorporated into their planning of a service program.

d) Counselor-client incompatability. Factors that contribute to incompatability in the counselor-client relationship were discussed along with methods for resolving this very serious problem in service delivery functions. Although incompatabilities can be resolved in relationships so that productive interactions occur, the process usually involves a lot of time. In some instances incompatability represents the very problem that clients seek help for and so their inter-personal behavior deserves the attention of the service worker. However, when this is not the case, or when other presenting problems deserve priority, trainees were encouraged to consider the transfer of the client to another service worker when this was feasible and would solve the incompatability problem. Since many of the service agencies represented in the project emphasized relatively short-term contacts, transfer of clients who were incompatable with the service worker may yield the most benefit in a short range of time.

e) Entrance factors that may negatively affect the counselor-client relationship. This theme involved those occasions when clients are coerced into seeking help from service workers by powerful, external agents. In such cases, external agents such as a court, an employer, a parent or spouse, etc. usually threaten the client with unpleasant or aversive consequences (e.g., unemployment, divorce) unless the client seeks help. It is not unusual for clients to resent this manner of entering counseling and to resist the help of service workers. The client may even view the counselor as an agent of or on the side of the coercer.

Each of the themes in this section of Phase II were discussed among the group members and trainers and trainees drew from their case experience to explore alternative solutions and methods of implementing these solutions. Frequently, participants were able to share the outcomes of solutions since the cases came from their past experience. With respect to ongoing cases, participants could offer alternatives for service workers.

Phase III: Development Phase

Although the original project proposal planned for this phase to cover a period of ninety-six hours over approximately eight months, this was the case only for the first group of trainees. Through our meetings with heads of participating agencies, it was indicated that the time commitment of a half-day per week for eight months put serious limitations on the service functions of staff members who were undergoing training. Reviewing the knowledge that we gained from our experience with the first group of trainees, we formulated a revised proposal for Phase III that reduced the number of contact hours of instruction to forty-eight over a period of approximately four months. This change was supported by the participating agencies and was implemented with the four subsequent training groups.

Phase III of the total program provided the opportunity for trainees to develop skills and other competencies to which they were exposed in the workshop sessions. This development occurred on the basis of practice, feedback, and reinforcement while on the job. It was expected and found that problems and situations occurred in the daily job activities of trainees that required practicing what had been learned in the conference and workshop session. It also was expected and found that problems occurred on the job that had not been covered in earlier training sessions. To achieve the degree of competencies required, continuous consultation and guidance was provided to trainees through the efforts of local professional mental health personnel and through weekly visits by the training staff. Thus, a number of training sessions in Phase III were developed based on the special needs identified by trainees. Appendix O contains a sample of themes that were developed during Phase III as well as a brief description of workshop content.

Professional staff from the Chatham County Mental Health Center worked with the project trainers in providing consultation and supervision. The Center staff, who were familiar with the Model Cities area and who by this phase had developed a strongly supportive relationship with the trainees, provided supervision and consultation through regularly scheduled group sessions on a weekly basis. In addition, the training staff, by coming to Savannah each week, met with the Center staff for consultation on the integration of learning experiences into the regular supervision which went on continuously. In addition, those trainees who wanted to meet with the trainers in an afternoon group session had direct, informal access to the staff. This relationship existed in this form for the remainder of training. This extended period of time permitted the trainee a realistic experience with the positive and negative factors in applying the skills of Phase II to his own caseload work. During Phase III, the entire staff provided guidance necessary to make this "practice" session a continued, fruitful learning experience.

VI. Data Collection Procedures

The evaluation of trainee progress across the various phases of the program relied on two sets of measures. A description of the specific measures appear in section VII that follows. The first set of measures focused on the attitudes of trainees toward individuals with problems of adjustment and toward the general effectiveness of their own behavior with respect to social influence. The second area of evaluation was concerned with basic interactional and counseling skills that are necessary to form and maintain effective counseling or helping relationships.

The attitude-related measures and the skills-related measures were obtained at three points in training. The initial collection of data occurred immediately prior to the beginning of Phase I. Pre-training data provided baseline information about trainees from which their progress, short term and long term, during the program could be viewed. The collection of data generally involved about three hours.

The second point of data collection occurred immediately following Phase II of the training program. Evaluation at this juncture provided information about the effectiveness of short-term, relatively concentrated training. The extent of change from pre-training sesssions to post-training sessions would represent the contributions of didatic instruction and practice through role playing during workshops. Post-training evaluation also provided a basis for viewing the additional contributions of Phase III during which time trainees would be applying the skills acquired in the earlier phases in direct client contacts. Presumably, skills would continue to develop through such application well beyond the practice they received in the workshops.

Final evaluation of trainees occurred following Phase III and usually within one month of this time. In order to maximize the turnout of trainees for this point of data collection, the evaluation for most trainees preceded the ceremony in which the continuing education certificates were awarded. The Phase III follow-up evaluation provided information on the extent to which trainees continued to show development of skills and the stability of change over the long-term of the program.

The basic plan of data collection employed repeated measures on the progress of trainees at pre, post, and follow-up points with respect to training. However, a control group also was used to assure that whatever changes occurred were not simply a function of time and the experience of trainees in their on-going work situation. At the onset of this project the request for trainees from the participating agencies resulted in a sample that was twice the size intended for the training units. The volunteers for training from each agency were divided randomly with one-half of the volunteers participating as trainees and one-half delayed for three months when a new training sequence began. The latter volunteers provided a no-training control group with which to compare the progress of the group undergoing training.

Members of the first training group were asked not to discuss their experiences with co-workers who were not involved in training with them. The rationale of a no-training control condition also was explained. However, in discussions with agency heads and supervisors, it was apparent quite early in the first training sequence that our request was not receiving compliance. Nor was this unreasonable considering the curiosity of controls and the enthusiasm of the trainees. This definitely presented a problem for considering the no-training control group as having no exposure to the concepts and skills involved in the training program. Nevertheless, the problem was ignored since the exchange of information between groups should detract from rather than enhance the effects of training as demonstrated by statistical comparisons.

VII. Description of Evaluation Materials

A. Attitude-related measures. These measures were administered to trainees during pre-training, post-training and follow-up evaluations and are described below.

The Community Mental Health Ideology Scale (CMHIS) was developed by Baker and Schulberg (1967) to assess an individual's adherence to a community mental health idealogy. Higher scores represent the person's greater commitment to a belief in the appropriate community care of the mentally ill as opposed to institutional care. Although the CMHIS has not yet been used to evaluate the effects of training in programs such as the present project, it was included because in our opinion it appears to be the best measure to date of attitudes regarding community care of the mentally ill. The items of the CMHIS appear in Appendix A.

The Opinions about Mental Illness Scale (OMI) is a questionnaire developed by Cohen and Streuning (1962) to assess the attitudes of individuals toward mental illness and mental patients. The OMI has been used in a large number of studies, the bulk of which support the conclusions that this measure is sensitive to difference among groups as well as to training effects. The authors of the OMI, utilizing the personnel of Veterans Administration neuropsychiatric hospitals, devised an inventory that measures five orientations or attitudes. According to the authors (1962, p. 360), these five factors, or orientations, are:

> Factor A - Authoritarianism. This is clearly identified with the California F Scale and includes its authoritarian submission and anti-intraception combined with a view of the mentally ill as an inferior class requiring coercive handling.
>
> Factor B - Benevolence. A kindly, paternalistic view towards patients whose origins lie in religion and humanism rather than science.
>
> Factor C - Mental Hygiene Ideology. A positive orientation which embodies the tenets of modern mental health professionals and the mental hygiene movement whose leitmotif is "mental illness is an illness like any other."
>
> Factor D - Social Restrictiveness. The belief that the mentally ill are a threat to society and must therefore be restricted in their functioning both during and after hospitalization.
>
> Factor E - Interpersonal Etiology. A circumscribed factor whose positive pole reflects the belief that mental illness arises from interpersonal experience especially deprivation of parental love during childhood.

Research has indicated that factors A and D seem to be related in terms of the sets being measured (Cohen and Struening, 1962; Struening and Cohen, 1963). In addition, high scores on factors A and D are negatively correlated with occupational status and educational level. Educational level and occupational status seem to be curvilinearly related to factors B and C. It has also been found that the particular orientation of the mental hospital administration has definite effects in terms of such behavioral indices as the average length of patient confinement, and per cent of population discharged (Cohen and Struening, 1964). In particular, the more authoritarian hospitals tend to have lower discharge rates, and greater average periods of confinement. Only one such study, however, has yet been done to study how such an authoritarian orientation may affect the actual behavior of an individual involved in an interaction with a mental patient.

In this regard, Ellsworth (1965) administered the OMI to sixty-five nursing personnel in a Veterans Administration neuropsychiatric hospital and measured the degree of congruence between professed attitudes of staff and behavioral ratings of their interpersonal behavior by the patients. It was found that those nursing personnel with an Authoritarian-Restrictive stance on the OMI were viewed quite negatively by the patients. These staff members were seen as 'domineering', rigid', 'inconsiderate', people who do not trust, nor relate well to the patients. Although the OMI has been primarily used with hospital personnel, it has also been used to measure the attitudes of individuals not connected with mental hospital such as student nurses (Smith, 1969), and community residents in Lousiana (Fournet, 1967). Thus, this measure has been used with different population samples.

The items of the OMI subscales of Authoritarianism, Benevolence, Mental Hygiene Ideology, Social Restrictiveness, and Interpersonal Etiology appear in Appendices C-G, respectively. Because the Authoritarianism and Social Restrictiveness subscales seem to be related in terms of the attitudinal sets being measured, statistical analyses were performed only on the former subscale.

The Internal-External Locus of Control Scale (LOC) measure was developed by Rotter (1966) as a measure of a generalized attitude, belief or expectancy which "relates to whether or not the individual does or does not have control over what happens to him." The individual with an internal locus of control orientation relies heavily on his/her own skills and abilities, and sees them as instrumental in securing rewards. On the other hand, those indicating a belief in external control are less likely to see their actions as influential determinants of reinforcement. Rather, the externally oriented person believes that the events that happen to him/her are a result of fate, luck, or power beyond his/her control and understanding. High scores reflect the belief that reinforcement is controlled by the forces in the environment and is not under the control of the individual.

Research generally shows that Internals in a problem solving or learning situation tend to gather more task-relevant information than Externals, since this is congruent with the Internal's belief in personal influence. Externals show a relatively small interest in task or problem relevant information, which is congruent with their belief of low influence over events in their lives (Rotter, 1966; Lefcourt, 1966; 1971). Lefcourt (1971) summarized the relationship between locus of control and cognitive activity, stating "Internals seem to know more about what is important to them, and seem more eager to gain information that would help increase their probabilities for success experiences."

On the basis of previous research it was expected that the internal versus external locus of control of trainees would relate to their progress in the training program. However, it was expected also that the long term effect of training, in which practice and application of skills took place with feedback and success experiences, would be to move trainees toward a greater internal locus of control orientation. The items of the LOC appear in Appendix B.

B. Skills-related measures. These measures were administered to trainees during pre-training, post-training and follow-up evaluations and are described below.

Counseling-Communication Skills Evaluation. This area of assessment of trainees was derived from the training program developed by Kagan and used in this project. In order to evaluate the progress of trainees through the program in the area of communication skills, videotaped recordings were made of twenty-three of the vignettes on the Kagan training film. Each vignette involved short statements by various individuals who were enacting a helpseeking or client role. The vignettes represented a wide array of problems and situations that were likely to occur in the work of our trainees. Vignettes were presented to trainees one at a time. Following each portrayal, the television presentation was put on hold and trainees were asked to record the response they would make to this client (see Appendix I for a copy of the record sheet). There was a possibility of a confounding effect in the evaluation of training outcome since the filmed vignettes employed in training were also the videotaped vignettes used for progress measurement. Nevertheless, this seemed to be a minor source of bias. During training, particular vignettes were used to practice only isolated counseling skills rather than all counseling skills or the integration of skills. Pre-, post- and follow-up assessment, on the other hand, considered the total effectiveness of trainee responses assuming an integration of skills. A second factor suggesting that this potential source of bias was inconsequential was the time between training and follow-up. This length of time would put a tremendous demand on trainees for the retention and recall of previously practiced responses. Even so, if trainees were able to memorize the isolated skill and the response practiced during the presentation of a particular vignette and repeated during the later evaluation, then this would be revealed by data analysis. Specifically, behavior change of this sort would be reflected in data analysis as a rather small change and scatter across each of the isolated skill measures.

Two raters who were graduate students in clinical psychology independently coded each subject's response to each vignette employing the counseling response below. Both raters in their graduate training had received supervised case work and were familiar with the counseling behaviors they were coding. The rating scores for the counseling categories below were expressed as the proportion of total statements. The agreement between raters ranged from .76 to .88, indicating a high and significant level of concordance in their coding.

Exploratory versus Non-exploratory Responding.

Exploratory responses are those responses to a client which encourage that person to stay deeply involved in the communication. At the same time, exploratory responses give the client freedom and latitude in what his/her next response will be. You, the counselor, respond in such a way that the client you are talking with is encouraged to become an active participant in the communication rather than a passive receiver of your advice and knowledge. You (the counselor) help the person feel free to reject, disagree, or modify your comments or observations. Your responses encourage the client to explore further,to go more deeply, to expand, to elaborate, and also to assume a great deal of responsibility for the direction and content of the interview or encounter.

Non-exploratory responses give the other person little opportunity to explore, expand or express herself/himself freely. Non-exploratory responses structure and limit the other person's next responses and imply that the interviewer or counselor will be able to solve the other person's concerns for him/her. In general, these responses tend to make the client passive and less and less involved in struggling with his or her own concerns.

Listening versus Non-listening Responding

Listening responses are those in which you (the counselor) actively and deliberately communicate to the other person that you are listening and trying to understand. Whenever what has been said by the client or other person is unclear to you or confuses you, you ask for clarification rather than let it slip by. Periodically, you paraphrase or check-out with your client what you think the client has said. Also, in order for you to test your understanding you ask the other person to confirm or deny what you think you have heard them say. Listening responses communicate to the other person that he/she is being taken very seriously and this often tends to encourage the other person to think carefully about his/her own statements. This in turn brings the client to take himself/herself very seriously and to begin listening at least as closely to their own concerns as you (the counselor) have been.

Non-listening responses are those responses which tend to focus more on what you (the counselor) want to say rather than on what the other person has said. These responses tend to give the client the impression that you are not trying to understand what he/she has said or what he/she might mean by what he/she has said.

Affective versus Cognitive Responding

Affective responses are those statements by the counselor that generally are oriented to emotions, feelings, bodily states or sensations of the client or other person (such as fear, anger, tenseness, and so on). These responses attempt to maintain and intensify the other person's focus on the feeling parts of their communication. Affective responses help to encourage the client to focus more clearly on underlying attitudes, values, and gut level bodily reactions.

Cognitive responses are those responses on the part of the counselor which are oriented toward the cognitive or content parts of the client's statement. These responses usually seek information from the other person that is of a factual nature. Cognitive responses attempt to maintain or shift the interaction to a thinking or analytic mode.

Honest Labeling

Honest Labeling responses are those by which you (the counselor) communicate to the other person that you are willing to deal directly and honestly with what you have seen and heard. Honest labeling by the counselor encourages the other person to be honest and specific in labeling his/her own perceptions, attitudes, and reactions. In order to do this you (the counselor) must be willing to accept the interpersonal risk and be capable of dealing with very intense, embarrassing or even socially taboo themes if, indeed, you have heard them.

Distortions

Distorted responses tend to be rather lengthy, vague and highly intellectual statements. Responses of this sort on the part of the counselor have the effect of modifying, distorting, "cleaning up" or diminishing the importance of the client's messages to which they refer.

Carkhuff's Index of Discrimination (1969).

This measure of counselor behavior is based on the assumption of a relationship between the discrimination of facilitative versus non-facilitative counselor interventions and the transfer of these discriminations into effective communication. The Carkhuff Index of Discrimination (see Appendix H) presents eight standardized and representative exerpts of persons (helpees) who are seeking help from a counselor (helper) for a personal problem. Each of the helpee exerpts are followed by four brief helper responses. This provides standardized and representative communications that counselors potentially might make in response to the helpee's statement. Trainees, considering the helpee-helper exchange, were asked to judge the facilitativeness of each helper's response to the helpee. Their judgements were based on the nine-point, descriptively anchored rating scale. The scale ranges from level one (not helpful, may hinder communication) to level five (optimally aids).

The trainee's score on this measure is based on his/her deviations from the ratings of experts. Thus, a low score on this test indicates high agreement with the discriminations of experts. Conversely, high scores show poor agreement with experts or greater inability to discriminate between effective and ineffective counselor behaviors. There are two forms (Form A and Form B) of this measure with different helpee-helper exchanges on each form. In order to establish the equivalency of forms, one-half of the first two classes received alternate forms during pre-training evaluation. No difference was found between the scores of trainees who received Form A versus Form B. Even so, the forms were counterbalanced with respect to order of administration.

C. Measures Related to Experience and Performance in the Work Situation

By far the most difficult evaluation plans to implement were the measures that attempted to gather information about the work situation. The original proposal called for trainees to maintain daily logs (see Appendix M) on a small sample of their clients. In addition, trainees were asked to fill out a brief Social History Blank and Symptom Checklist (see Appendix M) following their first contact with new clients. No other assignment of the project elicited more objections from the trainees or less cooperation. Persuasion, encouragement and explanations on the part of the staff failed to increase log-keeping beyond a sporadic rate. A simplification of the log to reduce the time required to complete it, also was unsuccessful. From the disclosures of our trainees we determine that they found this seemingly small amount of paper work aversive and difficult to fit into their work schedule. Probably of greatest importance was that the view of our trainees put greater priority on the needs of their clients. Nevertheless, the logs that were kept provided valuable information to the trainers during the first year of the project with respect to demographic characteristics of clients served by the various agencies, the types of services provided by our trainees, the nature and frequency of adjustment problems among clients, and service planning abilities of the trainees. The logs were abandoned after the second training class. No statistical analysis was feasible on the logs that were kept.

To supplement the information that was to be provided by the logs, the training staff in Savannah attempted to accompany trainees on a periodic basis in their work situation. However, this opportunity for observation, feedback and discussion of on-the-job experience also frequently was met with resistance from the trainees. From our discussion this did not appear to stem from problems in the trainee-trainer relationship. For the most part these realtionships were relaxed, close, open and mutually trusting. Rather, trainees worried that the presence of a stranger during their case contacts might exacerbate the difficulty they already had in establishing trust with their clients. One of the earliest and more frequent problems reported by trainees was that of overcoming the lack of confidence or distrust that many of their clients had for community services agencies.

A third approach to this general area of information was the Client Reply Blank (see Appendix M) instituted in the second year of the project. The identity of both the trainee and client were anonymous with respect to this form which asked clients to report their opinions about the services they received. An addressed and stamped envelope was given to clients along with the questionnaire following each helper-helpee contact. The questionnaires were dated so that the data could be examined in conjunction with the phases of training. However, the low rate of return of the questionnaires made the analysis of data unfeasible.

In summary then, our efforts to gather data relevant to the work situation yielded information that was useful to program planning though not amenable to data analysis. Our efforts perhaps were most informative about the methodological problems related to data collection with respect to experiences and performance at work.

D. Post-Session Evaluations

This brief measure was completed by trainees at the close of training sessions (see Appendix L). Briefly, the questionnaire aided trainers in evaluating the session content and their manner of delivery from the point of view of the trainees. This information was discussed among trainers in an effort to identify the strengths of presentations and to improve upon the weaknesses.

E. Other Measures

Occasionally, trainees were asked to complete questionnaires or collect data that would help them understand certain content areas that were covered during particular training sessions. This data collection was not for the purpose of statistical analysis but rather was included for their educational value. For example, trainees identified a behavior for self-observation and maintained daily records during their introduction to behavior change methods. One of the Phase III sessions considered reinforcing events and the clarification of values (Simon, Howe, and Kirschenbaum, 1972). Trainees completed a grid wherein they listed twenty events they enjoyed or found pleasant. Subsequently, in adjacent columns they rated various characteristics of these reinforcing events. The information was examined and the implications discussed within the group.

CHAPTER V

RESULTS

The first step of data analysis involved the comparison of training and non-training groups who were formed from the initial volunteers of participating agencies at the beginning of this project. The results are presented in Table 2 (see Appendix P). With respect to the attitude-related measures, the scores of the training group collected at the pre-training evaluation did not differ significantly from the scores of the no-training control group evaluated three months later. However, two differences occurred between these groups with respect to communication or counseling skills. The control group had a significantly higher proportion of affective responses as well as distorted responses than their counterparts. Considering the nature of these differences, however, it would appear that the no-training control group was no more skillful in their overall counseling interventions following three months of on-the-job experience than the training group when they began training three months earlier. The results that follow indicate that trainees showed substantial improvement with respect to counseling skills following training and these changes were maintained at follow-up evaluation.

The analysis of attitudes and skill related measures employed two factor analyses of variance with repeated measures on the last factor. The summary of _F_ - values are reported in Appendix P, Tables 3-16. As indicated in the previous chapter, the locus of control dimension was expected to affect the progress of trainees in the program. Thus, the planned analyses included trainee differences on the LOC as one of the factors in the analyses of variance, whereas the second factor represents the repeated measures that were collected on trainees before and after training. Trainees whose scores on the LOC scale fell toward the extremes were assigned to _internal control_ and _external control_ groups. Trainees whose scores fell at or adjacent to the median were dropped from data analysis in order to provide separation between internal and external groups and to permit an equal number of trainees per cell.

As indicated in the previous chapter, for various reasons trainees were unable to return for the scheduled post-training or follow-up data collection sessions. Make-up data collection sessions were especially scheduled for these absentees and some of the missing data was recovered. However, because of missing data, analyses were performed for the pre- and post-training scores and separate analyses were performed for pre-, post-, and follow-up training scores. The presentation of findings below report the results of the trainees progress across pre-, post-, and follow-up sessions since the separate analyses generally did not produce substantially different results. Finally, the tables report the results of analyses for the first year of the program and for both years combined. The outcome of these analyses are essentially alike and so the results of the combined analyses are presented below. However, the interested reader may wish to examine the results of the first year separately since this represented the pilot period during which time the content and methods of the program were refined in prelude to the second year.

Data analysis generally revealed rather negligible attitude change on the part of trainees across the various phases of the program (see Table 3). The exception was a change in the attitude of benevolence toward the mentally ill. Trainees showed a very large increase in taking a kindly, paternalistic view of patients as a consequence of Phases I and II of training. Although benevolence scores declined somewhat by the end of Phase III, they still remained higher in benevolence than they were prior to undergoing training. Expectations that trainees would develop a more internal locus of control orientation towards events in their lives and a less authoritarian attitude toward the mentally ill over the course of training was not supported. Nor did trainees change with respect to beliefs in a mental hygiene ideology or an interpersonal etiology. Although first year trainees showed a significant change in Community Mental Health Ideology across training, this result was not obtained in the combined analysis. Essentially in the first year group, *internal control* trainees increased their belief in the community care of the mentally ill as they progressed through the program, whereas *external control* trainees decreased their belief in a community mental health approach. However, caution should be exerted in interpreting this finding since it is based on a smaller group of trainees.

With respect to the acquisition of appropriate counseling-communication skills, results generally show improvement on all dimensions. With respect to exploratory (as opposed to non-exploratory) responding all trainees showed an extremely low proportion of this counseling intervention prior to training ($\overline{M}$ = 4.92%). In contrast, immediately after Phase II, trainees showed a significant and substantial increase in exploratory behavior ($\overline{M}$ = 60.25%). Even though follow-up evaluation showed a decline in this skill category ($\overline{M}$ = 43.4%), the proportion was still considerably and significantly higher than when trainees began. There was also a tendency for *internal control* trainees to employ this type of communication in their interventions ($\overline{M}$ = 45.17%)

overall more than _external_ _control_ trainees ($\overline{M} = 27.28\%$).

Similar results were obtained with respect to the acquisition of affective responding (as opposed to cognitively oriented responses). Prior to training, trainees engaged in a very low proportion of interventions oriented toward the affective mode of interaction ($\overline{M} = 2.33\%$). Substantial and significant gains occurred during the short-term period of training ($\overline{M} = 42\%$) and this change was maintained at follow-up evaluation ($\overline{M} = 38\%$). Thus, training greatly increased trainee attention to the emotional state of clients. The progress of trainees also was related to their locus of control orientation. Internal control trainees showed a more rapid acquisition of this skill during training than did _external_ _control_ trainees. Internals and Externals did not differ prior to training ($\overline{M} = 1.17\%$ and 3.5%, respectively) but were considerably different immediately after Phase II ($\overline{M} = 59.5\%$ and 24.5%, respectively). A slight decline by internals ($\overline{M} = 46\%$) and a slight increase by externals ($\overline{M} = 30\%$) during Phase III, reduced the discrepancy between them at followup.

With respect to Honest Labeling responses, trainees again showed a low proportion of these responses prior to training ($\overline{M} = 7.75\%$) but significantly and substantially increased this type of response at post-training ($\overline{M} = 16.83\%$) and at follow ($\overline{M} = 29.83\%$). On the analysis of pre- and post-training scores a significant effect of locus of control was found that did not occur with follow-up data. Specifically, _internal_ _control_ trainees significantly increased their honest labeling interventions during Phases I and II of training, whereas _external_ _control_ trainees did not change from their initial low level of response.

The analysis of variance for Distorted responding yielded non-significant results. However, inspection of cell means for the various points of data collection revealed that distorted responses occurred at a very low rate among trainees even prior to training ($\overline{M} = 9.5\%$), decreased at post-training ($\overline{M} = 2.3\%$), and accounted for less than one percent of trainees' interventions at follow-up.

The results for Listening responses (as opposed to nonlistening responses) showed significant improvement as a function of training. The occurence of this counselor behavior was very low prior to training ($\overline{M}$ = 10.09%) and increased substantially following Phases I and II of training ($\overline{M}$ = 71.82%). Although during the followup phase of training there was a significant lowering of this response, nevertheless the level of listening type communications among trainees was significantly higher ($\overline{M}$ = 50.05%) than at pre-training evaluation. Trainees who had an internal locus of control orientation generally showed a greater proportion of listening behaviors than their counterparts and were more responsive to the training on this skill. No difference existed on listening behaviors at pre-training for the two groups of trainees. However, at post-training evaluation, internals ($\overline{M}$ = 87.64%) were significantly higher on this counselor behavior than were externals ($\overline{M}$ = 56%). The difference between internals ($\overline{M}$ = 58.73%) and externals ($\overline{M}$ = 41.36%) diminished by followup evaluation.

Carkhuff's Index of Discrimination was a measure of the trainee's ability to discriminate facilitative versus nonfacilitative responses. No significant differences were found on this skill across pre-, post- and follow-up training evaluations. However, the direction of change was toward better discrimination during the training phases. In addition, trainees showed fairly good discriminative skills ($\overline{M}$ = 1.30), considering the possible range of scores from high discrimination (C least discrepant) to low (4 most discrepant). There was a tendency for internals to show better discrimination than externals when only pre- and post-training evaluation scores are compared, but this difference is not found when follow-up measures are included in the data analysis.

Additional Findings. Further analyses were performed in order to explore the potential relationship between the mental health attitude measures and the progress of trainees with respect to the development of counselor skills. Two factor analyses of variance with repeated measures on the last factor were employed in this data analyses. The summary of F - values are reported in Appendix P, Tables 7 through 16. Separate analyses were performed to evaluate the progress of trainees in their mastery of counseling skills as a function of Authoritarianism, Benevolence, Mental Hygiene Ideology, Interpersonal Etiology and Community Mental Health Ideology factors. For each factor, trainees whose scores fell at the extremes of the scale were assigned to low and high groups (e.g., low benevolence versus high benevolence). Trainees whose scores fell at or adjacent to the median were dropped from data analysis in order to provide separation between low and high groups and to permit an equal number of trainees per cell in the data analysis.

Although some relationships were observed between mental health attitudes and the progress of trainees, the relationships revealed no consistent moderator effects such as was found with the locus of control dimension. For this reason, the presentation of results that follows should be examined very conservatively.

Low authoritarian trainees showed significantly higher proportions of exploratory responses than did high authoritarian counterparts. There was also a tendency for low authoritarians to show better progress in the acquisition of affective responses. However, both results are based on scores obtained at pre-and post-training evaluations.

Trainees who scored high on benevolence toward mental patients showed only slight increases in their proportion of honest labeling responses, primarily because of their greater tendency to engage in this counselor behavior prior to training. Trainees who scored low on benevolence showed very low proportions of honest labeling prior to training and had not changed significantly at the end of Phase II of training. However, the evaluation following Phase III of training showed a significant increase of this response among trainees who scored low on benevolence.

Several of the attitude measures related to the ability of trainees to discriminate facilitative counselor responses. However, as the summary tables indicate, the relationships were very unstable and varied with the points at which evaluations occurred and with year of the training program. With this in mind then, better discrimination tended to occur in relation to a more benevolent attitude toward mental patients, a greater orientation toward the community treatment approach and less orientation to the tradition mental hygiene-illness concept.

CHAPTER VI

SUMMARY AND DISCUSSION OF FINDINGS

Measuring the degree of attitudinal and behavioral change in any number of helping areas is an extraordinarily difficult task that confronts investigators. A rigorous evaluation of in-service training programs such as the present project is made even more difficult by at least three factors which we believe are unique to in-service training.

First, our trainees varied widely with respect to their levels of prior training and experience. It is likely that intra-professional training programs, e.g., nursing, social work, education, psychology, involve more homogeneous groupings of students than is characteristic of our trainees. Nevertheless the intention of the present project was neither to recruit for nor train individuals as mental health workers or other similarly uniform and narrow professional roles. Rather the intention of the program was to be responsive to the different and changing needs of all of our participants.

Methodological controls for the considerable variability among our trainees, such as randomization or matched control groups, was impractical if not impossible because of restrictions imposed by agency policy. No statistical procedures, such as analysis of covariance, can control for the large initial differences that were found among trainees who were already at work in their chosen profession.

Even so, the evaluation of the quality of counseling behavior among our trainees prior to training showed a fairly consistent and low level of facilitative responding. Their verbal communications to the expressed needs of "clients" as portrayed in the test situations offered little encouragement for clients to explore or expand upon their concerns, put greater emphasis on what the helper had to say as opposed to what the helpee was saying, and gave minimal attention to the emotional experiences of those to whom help was given.

The magnitude of change among our trainees over the course of training suggests that the program was responsive to the needs of trainees regardless of their diverse backgrounds. Attitudinal change was less remarkable than was behavioral change. An exception with respect to attitudinal change was the significant increase in benevolence toward psychologically maladjusted individuals.

Recalling the definition of benevolence as presented in Chapter IV, this attitude was qualified as having its origins "in religion and humanism rather than science." For the most part our trainees were deeply religious and had chosen a professional role that involved help and care of others. For this reason, their benevolent attitude toward others appears to originate from their religious background and humanistic persuasion rather than from the training program itself. The effect of their training experience seems to have extended the range of their benevolence to include mentally ill persons. The content of Phase I, including efforts to demyth and destigmatize mental illness, successfully increased the benevolence of our trainees toward patients. This change was maintained over the longer course of the program.

However, no change occurred as a result of the program with respect to the measures of other attitudes and beliefs held by our trainees toward psychologically maladjusted individuals. This represents a failure of the information of Phase I and the experiences provided in Phases II and III to affect positive attitude change. One explanation of this failure is that our trainees for the most part already maintained positive attitudes in the other areas which were assessed. The vocational preferences of our trainees as well as the hiring practices of agencies may have worked to select staff who already possessed attitudes supportive of the goals of the training program. For example, a view of the mentally ill as an inferior class requiring coercive handling or the rejection of a community care orientation are negative attitudes that contradict a professional role within community oriented, human services delivery systems.

The effect of training on counselor behaviors is much more clearcut. Following the brief and intensive workshop series of Phase II, trainees showed a substantive increase in their utilization of facilitative counselor interventions. Trainees made a more active and deliberate effort to communicate their desire to listen to and understand the needs and problems of others. Communications of this sort advise the client that he or she is being taken seriously by the service worker and this in turn is likely to increase the client's involvement in the work they have before them.

Trainees also increased their utilization of exploratory responding which encourage the client to go more deeply into their experiences or to expand and elaborate in the communication process. In this way, the helper provides alternative views for the clients consideration but does not give primacy to their own opinions nor impose them on the client. This type of communicative behavior on the part of counselors helps encourage an active, responsible role for the client in the helping situation.

As a consequence of training, trainees increased their attention to emotional experiences on affective states such as anger, tension, sadness, etc. and were more willing to involve themselves in the intense, perhaps socially embarassing themes of interpersonal communication. These aspects of experience are those that clients find extremely difficult to disclose about and may even deny, distort or ignore. That counselors attend to these aspects of the client's experiences is made even more important because they often underlie the client's difficulties with others and are often withheld from family, friends, or important others.

The ability of clients to discriminate facilitative counselor responses showed less change than their ability to engage in facilitative counselor behaviors. However, both their scores on the Carkhuff Scale and the low proportion of distorted responding on the Kagan test indicate that our trainees were able to recognize and avoid grossly inappropriate behaviors. It would appear that at the outset of training, our helpers had accurate perceptions of clients' communications and through skill training found facilative ways to intervene.

Although it was unfeasible to control for the wide differences that existed among trainees at the outset of the program, one counselor variable was chosen for inclusion because of its performance in previous research. This counselor difference was the *locus of control* dimension (Rotter, 1966; Lefcourt 1966; 1971). Following expectations, this attitude measure successfully predicted the progress of trainees throughout the training program.

Trainees who attributed less social influence or control of outcomes to themselves also progressed more slowly in a program designed to increase their interpersonal effectiveness. Conversely, trainees who generally believed that events in their lives are under their behavioral influence showed very rapid acquisition of facilitative counselor behaviors. Evenso, the follow-up evaluation that came after the end of Phase III found *external* trainees nearly at par with *internals* with respect to skill development.

Although the extended experiences of Phase III seemed to benefit externals more so than internals, future projects may find the locus of control dimension a helpful screening method to alert trainers to individual differences in trainee progress. Most importantly, special consideration should be given to training procedures that potentially can facilitate the progress of externals. This might involve time-extended and more intensive training experiences, altogether different experiential methods, or intermittent booster sessions.

A second factor that affects a rigorous evaluation of this and similar training programs involves the needs and policies of the trainee's agencies. For the purposes of systematic evaluation it would be more desirable to have worked with the staff of one or two agencies. In so doing, there would be greater uniformity of agency needs and policies both of which are potent determinants of our trainees day-to-day functioning. Obviously, just as trainees differ greatly before training, so do the needs and policies of agencies. These can be independent of if at times not counter to some of the attitudes and behaviors which develop as a function of training. Nevertheless, the purpose of the project was to develop a comprehensive continuing education program that was responsive to and complemented a broad spectrum of human service delivery systems. Parenthetically, one effect of the training program was the adaptation of agencies to their trainees' new learning.

The most relevant gain of agencies is the more effective and efficient delivery of services defined by the agencies' roles and policies. For example, Appendix O includes a special Phase III session designed to help trainees organize and conduct meetings, including Robert's Rules of Order. Though this may seem an unusual theme of training it was in direct response to problems in service delivery of one unit of trainees. The role of this unit was to identify groups of individuals with common needs and problems that would benefit by group cohesiveness and action (e.g., high frequency of burglaries or breakins in the housing project). Trainees complained that they had difficulty bringing people together for a meeting, that attendance was poor at the scheduled meetings, and that meetings became disorganized or disruptive. Essentially then, trainees in this situation were unable to provide effectively the services for which they were responsible. A side effect for these and other trainees was that they became more effective in organizing and managing agency meetings for which they were responsible.

Generally, the scope of services delivered by the staff of agencies broadened to include the psychological welfare and needs of their clients. In one circumstance encountered early in the project, the degree of policy change on the part of the agency was rather important to the psychological welfare on its staff. The service unit involved had a primary responsibility for the identification of individual needs and then referral of these individuals to the appropriate human services systems. The trainees from this newly formed service unit were dissatisfied with their helping role. Although they valued the content of their training experience, their participation in the program in fact exacerbated a declining morale. Essentially, they were acquiring skills that they were not permitted to employ. Their complaints to the training staff centered on the restrictiveness of policies of their agency. Specifically, they preferred to go beyond the identification of clients needs to help them explore and clarify needs, to intervene directly with service delivery when feasible rather than refer, and to follow-up with clients after first contact. Meetings between project and agency supervisors brought about greater flexibility in the role of their staff--though some constraints continued--and this considerably improved the level of satisfaction among this group of trainees.

The needs and policies of agencies definitely influenced the content of the training program. At times the training staff were concerned that sessions planned for Phase III might have relevance only to agency staff who identified the problem area which gave rise to training theme. However, the post-session evaluations of trainees usually indicated that the experience was relevant to staff of other agencies.

The most significant influence of agency needs on training was with regard to the time commitment of agency personnel. As indicated in Chapter IV, our experience with the first group of trainees who went the full duration of the planned program indicated that this amount of time was impractical. The loss of manpower hours seriously restricted the functioning of agencies in their primary mission of human service delivery.

A third and final methodological problem which makes vigorous evaluation of training difficult is the considerable differences among clients served by the various agencies and trainees. Again, this appears to be a problem for evaluation that is fairly unique to in-service training programs. Types of clients differed markedly from trainee to trainee and it was entirely unfeasible to restrict trainees to certain types of clients simply to achieve uniformity for the sake of program evaluation. For this reason, it is difficult to ascertain the effect that types of clients had on the practical counseling experiences of our trainees.

This problem is particularly relevant to Phase III of training during which time the trainees had extended contacts with their clients. Indeed, the purpose of Phase III in part was to provide the opportunity for trainees to develop skills and other competencies to which they were exposed in the previous workshop sessions. The experimentially oriented Phase III training and the in-service contacts provided trainees with practice, feedback and reinforcement in "doing" roles. The trainees were able to experience that something works and how it works. As can be seen, the progress of trainees during this portion of training was very much tied to their case experiences. The development of skills and the refinement of their use may have been facilitated or inhibited depending on the nature of clients served by trainees' agencies.

The comparison of training and no-training control groups provides some reassurance with respect to the overall effectiveness of the project and confounding effects of agencies and clients. As the reader may recall the first group of trainees who volunteered for the project were divided with equal numbers from each agency. One-half of the trainees began the program immediately, whereas one-half of the trainees delayed training for a period of three months. The no-training group after three months of in-service experience showed no more development of facilitative counseling behavior than the level of skills shown by the training group prior to training. However, in the same three-month period, trainees who underwent training showed considerable change toward increased facilitative responding. Thus, training in conjunction with in-service practice yielded positive development of counselor hehavior. In-service practice alone had negligible influence on the quality of counseling behavior as reflected by our measures.

In addition to the attitudinal and behavioral measures that were employed for program evaluation, the subjective impressions of the trainees, based on their ratings of training segments, may provide insight to what they valued most about their experiences. For the most part the averaged ratings of training segments were high ranging between level 4 and level 5 (see Appendix L), on the five-point rating scale. From the point of view of the trainees the most successful features of training involved transactions between community agencies. This is reassuring since a high priority objective of the program was to identify for trainees the available human and material resources of community health agencies, mental health agencies, and other human services delivery systems. Another facet of this objective was to identify the services of agencies in order that appropriate referrals could be made. The averaged ratings of 4.8 were assigned to sessions involving visits from representatives of other agencies and ot sessions featuring referrals (see Appendix O).

One of the less successful features of the training program involved the training staffs' field visits with the trainees. The field visits were undertaken to determine in an experimental way what trainees actually did on their jobs. Staff would accompany trainees as they worked in offices, visited homes, or to wherever context it was that a trainee worked. Some of the trainees were resistant to field visits, not wanting to disrupt their activities with clients and perhaps were sensitive to the presence of an observer. The logistics of scheduling a three-party encounter also created problems for the trainees. In other situations it was very difficult to assess or understand what was taking place by the very nature of the work that the trainee was involved in.

There were two unforeseen factors that arose during the course of the project that made a more rigorous and thorough evaluation of the program effectiveness difficult. The first factor involved the systematic and meaningful assessment of in-service trainee experiences (see Chapter IV). Although information was obtained that was helpful in the development of the training program, the methods of assessment that were employed failed to provide usable data for rigorous evaluation. This is a very serious problem with respect to effective evaluation of in-service training and is given further consideration below. The co-principle investigators and the Savannah training staff devoted many hours to the pursuit of solutions which were not forthcoming.

The primary mechanism for in-service evaluation was daily logs kept by trainees on a small sample of their clients. The logs were turned in weekly to the trainers and later in the program were collected from trainees at their agencies on regular basis. The problem was that many trainees did not maintain their logs or were irregular in their maintenance of logs.

The most frequent complaint by trainees was that supplying information invaded the privacy of clients and that obtaining informed consent was disruptive to the helping relationship. Specifically, their problem involved the client's feelings of distrust and despair that are commonly found among citizens served by these agencies. The most difficult feature in establishing helping relationships was overcoming these particular client feelings that all too often were appropriate considering the client's past experiences. Thus, seeking the client's permission to use information for the benefit of strangers would exacerbate the distrust and despair of clients and run counter to the goals of training.

A second complaint was that the logs required too much of their time, time that trainees felt could be better applied to service delivery. Although the format of the log was simplified, this skill required trainees to take time away from clients and usually immediately following the contact. The problem we faced was that logs could be oversimplified to the point that meaningfulness of feedback would be sacrificed to ease administration.

Relatedly, as is the case with most individuals, our trainees found that maintaining logs on clients was in and of itself an unpleasant annoyance. In an effort to increase the incentive for this record keeping, we attempted to make the CEU's (see Appendix N) contingent on each trainee turning in their weekly logs. This did not substantially improve our collection of logs. We considered monetary rewards but this was not provided for in the project budget. We considered attempting to arrange a day off from work for those trainees who maintained perfect log records. However, this too was unfeasible.

Other alternatives for assessing in-service experience were attempted (see Chapter IV) but for about the same reasons these evaluative methods were unsuccessful. The client contact records and folders of agencies were another possibility that was explored. However, the client confidentiality issue again presented itself along with the considerable difference in records from agency to agency. Except for demographic information about clients there was very little overlap on the kinds of information recorded about clients. Other agencies did not keep records on individual persons served by trainees, but rather had reports of staff activities in the community.

A second factor that affected the evaluation of the program was the very high turnover of staff of participating agencies. Close to one-fifth of our trainees changed jobs and/or moved from the cachment area served by our program. Typically, this change occurred during the longer training period of Phase III. There is the possibility that the substantial changes that occurred across the course of the program was a function of those who left the project rather than the training itself. More specifically, these workers who changed employment may have been motivated by their dissatisfaction with the nature of their work or by their poor performance on the job. If this were the case, then it would be expected that the remainers in the program possess better counseling skills than those who defected. Thus as defectors left the program, the improvement scores of the post- and follow-up training evaluations would be inflated.

There are a number of arguments against this alternative explanation, and some reasons for arguing the converse, i.e., the more qualified trainees defected. The colleagues of defectors reported that in most cases those who left for other jobs were going for a better paying position and/or for a higher status position. This argues for the effectiveness rather than an ineffectiveness on the part of the trainees who defected from the program. Likewise, many of the defectors obtained employment in the private sector rather than public service positions. This occurred during a period of economic recession when private sector positions traditionally decrease and public sector jobs increase. Thus, defectors who took positions in the private sector were competing for fewer available positions.

A final argument against the possible confounding effect of defectors on the outcome of the program involves pre-training evaluation performance. Facilitative counseling behaviors were uniformly very low in frequency among all trainees at the outset of training, such that it would be difficult to predict remainers or defectors prior to training. Thus, it was the training itself or possibly training in interaction with trainee differences that produced positive change in counseling skills. Evenso, the moderator effect of remainer versus defector differences would be illuminated were it possible to perform follow-up evaluations on defectors.

Because of the large turnover of community workers in the human services delivery systems, the need for an ongoing program of training is apparent. The staff of the Chatham County Southside Mental Health Center had a new training group underway at the end of the present project and planned to maintain an ongoing program on a less frequent basis for the community services agencies of this area. During the second year of the project, the resources and staff of the Mental Health Center were primarily responsible for the continuation of the training program. These individuals had participated closely in planning and conducting of training with the co-principle investigators during the previous year. Their earlier collaboration in the choice, development and modification of content, learning methods and techniques allowed them to take over responsibility for subsequent and future training of community workers.

The role of the co-principle investigators in the second year was reduced basically to consultation with the local staff. Although earlier plans called for a shift in responsibility for program evaluation to the Savannah staff during the second year, this did not occur. The retention of evaluative responsibility by the investigators was primarily a matter of convenience and the institutional resources available to them. Even so, the Savannah staff were well acquainted with the evaluation procedures and were kept informed of the first year results as they were prepared.

The success of the Savannah staff in conducting training during the second year serves to encourage the application of this training format in other cities where community service agencies and mental health centers have the desire to work in concert toward similar goals. Specifically, human service delivery systems other than mental health care, need staff who are skilled in human relationship skills that permit them to effectively serve those who need their helping resources. In many instances, our trainees found that their regular services were secondary to the psychological problems that were underlying the client's service needs. In other cases, the adjustment problems of the client prevented effective service delivery. Still other clients that our trainees worked with would have established long-term dependencies on services without the psychological interventions of their community worker.

One major concern of the project staff and agency administrators was the potential and undesired shift of their staff's role to mental health workers. However, the feedback from directors and supervisors was that this did not evolve. The administrators of agencies increased their regard for the project as the progress of their staff became evident in their casework. Following the first training group, eleven percent of the remaining trainees involved agency supervisors who volunteered for participation in the program. Another example of the acceptance and motivation of agencies' directors in behalf of the project was their recruitment efforts for new trainees. During the period of time that the training staff were involved with an on-going group of trainees, the Neighborhood Continuing Education Project Office in Savannah was receiving a continual flow of staff referrals from agencies. Other agencies, during the two year period of the project, contracted on a separate basis with the Mental Health Center staff or with other professionals in the community for similar training of their staff though more tailorized to the needs of these agencies.

In closing, the project met the objective of developing a comprehensive and coordinated continuing education program of mental health training for community workers engaged in the delivery of human services to clients in the cachment area formerly known as the Model Cities areas. Most certainly, a myriad of trainee, agency and client factors that were unaccounted for interacted with the basic training program to influence the development and progress of trainees in their acquisition of a repertoire of counselor skills that will increase the effectiveness of their interventions with their clients. Nevertheless, the basic concept and procedure of the training program was applicable to the diverse needs, policies and backgrounds of agencies and their staff. Although this diversity prevents rigorous evaluation, it has many redeeming features with respect to the practical applications of this program to the human service delivery systems of Savannah and other communities. Except in very large cities, agencies such as those which participated in the present project infrequently have a large enough staff to undertake such a training program. Even if this were not the case, a staff turnover similar to that which we experienced, would require fairly frequent agency training programs. Finally, the cost of such a program were it to be undertaken by each agency separately would be prohibitive. However, communities by pooling their resources would be able to implement conjoint training programs that would be affordable, practical, and suitable fo the diverse needs of the agencies, staff, and the clients they serve.

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APPENDIX A

COMMUNITY MENTAL HEALTH IDEOLOGY SCALE

Name: ______________________________

Date: ______________________________

Agency: ____________________________

COMMUNITY MENTAL HEALTH IDEOLOGY SCALE

Read the following statements and decide whether you strongly agree, moderately agree, slightly agree, slightly disagree, moderately disagree, or strongly disagree with each. Circle the words which best describe how you feel. Be careful not to skip any statements.

1. Every mental health center should have formally associated with it a local citizen's board assigned significant responsibilities.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

2. Our time-tested pattern of diagnosing and treating individual patients is still the optimal way for us to function professionally.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

3. With our limited professional resources it makes more sense to use established knowledge to treat the mentally ill rather than trying to deal with the social conditions which may cause mental illness.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

4. Our responsibility for patients extends beyond the contact we have with them in the mental health center

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

5. A significant part of the psychiatrist's job consists of finding out who the mentally disordered are and where they are located in the community.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

6. Such public health programs as primary preventive services are still of little value to the mental health field.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

7. A mental health program should direct particular attention to groups of people who are potentially vulnerable to upsetting pressures.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

8. The planning and operation of mental health programs are professional functions which should not be influenced by citizen pressures.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

9. Mental Health programs should give a high priority to lowering the rate of new cases in a community by reducing harmful environmental conditions.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

10. The mental health specialist should seek to extend his effectiveness by working through other people.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

11. A mental health professional can only be responsible for the mentally ill who come to him: he cannot be responsible for those who do not seek him out.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

12. Our program emphasis should be shifted from the clinical model, directed at specific patients, to the public health model, focusing upon populations.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

13. Understanding of the community in which we work should be made a central focus in the training of mental health professionals.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

14. The control of mental illness is a goal that can only be attained through psychiatric treatment.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

15. A mental health professional assumes responsibility not only for his current caseload but also for unidentified potentially maladjusted people in the community.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

16. Our current emphasis upon the problems of individual patients is a relatively ineffective approach for easing a community's total psychiatric problem.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

17. Our professional mandate is to treat individual patients and not the harmful influences in society.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

18. Our efforts to involve citizens in mental health programs have not produced sufficient payoff to make it worth our while.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

19. The locus of mental illness must be viewed as extending beyond the individual, and into the family, the community, and the society.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

20. Mental health professionals can be concerned for their patients' welfare only when having them in active treatment.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

21. Mental Health consultation is necessary service which we must provide to community caregivers who can help in the care of the mentally ill.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

22. Caregiving agents who worked with the patient before and during his contact at the mental health center should be included in the formulation of treatment plans.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

23. A psychiatrist can only provide useful services to those people with whom he has direct personal contact.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

24. Skill in collaborating with nonmental health professionals is relatively unimportant to the success of our work with the mentally ill.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

25. The mental health center is only one part of a comprehensive community mental health program.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

26. Mental health professionals should only provide their services to individuals whom society defines as mentally ill or who voluntarily seek these services.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

27. We should deal with people who are not yet sick by helping them to develop ways of coping with expected life difficulties.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

28. We should not legitimately be concerned with modifying aspects of our patient's environment but rather in bolstering his ability to cope with it.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

29. It is a poor treatment policy to allow non-psychiatrists to perform traditional psychiatric functions.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

30. Since we do not know enough about prevention, mental health programs should direct their prime efforts toward treating the mentally ill rather than developing prevention programs.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

31. The hospital and community should strive for the goal of each participating in the affairs and activities of the other.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

32. Social action is required to insure the success of mental health programs.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

33. In view of the professional manpower shortage, existing resources should be used for treatment programs rather than prevention programs.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

34. Each mental health center should join the health and welfare council of each community it serves.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

35. The responsible mental health professional should become an agent for social change.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	7	6	5	3	2	1

36. We can make more effective use of our skills by intensively treating a limited number of patients instead of working indirectly with many patients.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

37. By and large, the practice of good psychiatry does not require very much knowledge abour sociology and anthropology.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

38. Community agencies working with the patient should not be involved with the different phases of a patient's hospitilization.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Points:	1	2	3	5	6	7

Note: Higher points reflect greater community mental health orientation.

APPENDIX B

LOCUS OF CONTROL SCALE

NAME: ____________________

DATE: ____________________

AGENCY: __________________

SOCIAL REACTION INVENTORY

This is a questionnaire to find out the way in which certain important events in our society affect different people. Each item consists of a pair of alternatives lettered *a* or *b*. Please select the one statement of each pair (*and only one*) which you more strongly *believe* to be the case as far as you are concerned. Be sure to select the one you actually *believe* to be more true rather than the one you think you should choose or the one you would like to be true. This is a measure of personal belief; obviously there are not right or wrong answers.

In some instances you may discover that you believe both statements or neither one. In such cases, be sure to select the *one* you *more* strongly believe to be the case as far as you are concerned. Also try to respond to each item *independently* when you are making your choice; do not be influenced by your previous choices.

REMEMBER

Circle that alternative which you *personally believe to be more true*.

I more strongly believe that:

1 a. Children get into trouble because their parents punish them too much.

b. The trouble with most children nowadays is that their parents are too easy with them.

2 a. Many of the unhappy things in people's lives are partly due to bad luck.

b. People's misfortunes result from the mistakes they make.

3 a. One of the major reasons why we have wars is because people don't take enough interest in politics.

b. There will always be wars, no matter how hard people try to prevent them.

4 a. In the long run people get the respect they deserve in this world.

b. Unfortunately, an indiviual's woth often passes unrecognized no matter how hard he tries.

5 a. The idea that teachers are unfair to students is nonsense.

b. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6 a. Without the right breaks one cannot be an effective leader.

b. Capable people who fail to become leaders have not taken advantage of their opportunities.

7 a. No matter how hard you try some people just don't like you.

b. People who can't get others to like them, don't understand how to get along with others.

8 a. Heredity plays the major role in determining one's personality.

b. It is one's experiences in life which determine what they're like.

9 a. I have often found that what [illegible]ng to happen will happen.

b. Trusting to fate has neve[illegible] as well for me as making a decision to take a defin[illegible] action.

10 a. In the case of the well [illegible]ent there is rarely if ever such a thing as an unfair test

b. Many times exam questions tend to be so unrelated to course work, that studying is really useless.

11 a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.

b. Getting a good job depends mainly on being in the right place at the right time.

12 a. The average citizen can have an influence in government decisions.

b. This world is run by the few people in power, and there is not much the little guy can do about it.

13 a. When I make plans, I am almost certain that I can make them work.

b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

14 a. There are certain people who are just no good.

b. There is some good in everybody.

15 a. In my case getting what I want has little or nothing to do with luck.

b. Many times we might just as well decide what to do by flipping a coin.

16 a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.

b. Getting people to do the right thing depends upon ability, luck has litte or nothing to do with it.

17 a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.

b. By taking an active part in political and social affairs the people can control world events.

18 a. Most people don't realize the extent to which their lives are controlled by accidental happenings.

b. There really is no such thing as "luck."

19 a. One should always be willing to admit his mistakes.

b. It is usually best to cover up one's mistakes.

20 a. It is hard to know whether or not a person really likes you.

b. How many friends you have depends upon how nice a person you are.

21 a. In the long run the bad things that happen to us are balanced by the good ones.

b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22 a. With enough effort we can wipe out political corruption.

b. It is difficult for people to have much control over the things politicians do in office.

23 a. Sometimes I can't understand how teachers arrive at the grades they give.

b. There is a direct connection between how hard I study and the grades I get.

24 a. A good leader expects people to decide for themselves what they should do.

b. A good leader makes it clear to everybody what their jobs are.

25 a. Many times I feel that I have little influence over the things that happen to me.

b. It is impossible for me to believe that chance or luck plays an important role in my life.

26 a. People are lonely because they don't try to be friendly.

b. There's not much use in trying too hard to please people, if they like you, they like you.

27 a. There is too much emphasis on atheletics in high school.

b. Team sports are an excellent way to build character.

28 a. What happens to me is my own doing.

b. Sometimes I feel that I don't have enough control over the direction my life is taking.

29 a. Most of the time I can't understand why politicians behave the way they do.

b. In the long run the people are responsible for bad government on a national as well as on a local level.

NAME: ______________________

SEX: M or F

AGE: ______

SOCIAL REACTION INVENTORY
ANSWER FORM

Circle that alternative which you personally believe to be more true.

*1. a b

2. a b

3. a b

4. a b

5. a b

6. a b

7. a b

*8. a b

9. a b

10. a b

11. a b

12. a b

13. a b

*14. a b

15. a b

16. a b

17. a b

18. a b

*19. a b

20. a b

21. a b

22. a b

23. a b

*24. a b

25. a b

26. a b

*27. a b

28. a b

29. a b

Note: Asterik (*) indicates filler items; underlined (_) answers score in the direction of External Locus of Control.

APPENDIX C

OPINIONS ABOUT MENTAL ILLNESS AUTHORITARIANISM FACTOR

NAME:______________________

DATE:______________________

AGENCY:____________________

OPINIONS ABOUT MENTAL ILLNESS

Read the following statements and decide whether you strongly agree, moderately agree, slightly agree, slightly disagree, moderately disagree, or strongly disagree with each. Circle the words which best describe how you feel. Be careful not to skip any statements.

1. If parents loved their children more, there would be less mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

2. One of the main causes of mental illness is a lack of moral strength or will power.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

3. Mental patients come from homes where the parents took little interest in their children.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

4. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everday life.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

5. The mental illness of many people is caused by the separation or divorce of their parents during childhood.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

6. People would not become mentally ill if they avoided bad thoughts.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

7. People who are mentally ill let their emotions control them; normal people think things out.

Strongly Agree   Moderately Agree   Slightly Agree   Slightly Disagree   Moderately Disagree   Strongly Disagree

8. If the children of mentally ill parents were raised by normal parents, they would probably not become mentally ill.

Strongly Agree   Moderately Agree   Slightly Agree   Slightly Disagree   Moderately Disagree   Strongly Disagree

9. When a person has a problem or worry, it is best not to think about it, but keep busy with more pleasant things.

Strongly Agree   Moderately Agree   Slightly Agree   Slightly Disagree   Moderately Disagree   Strongly Disagree

10. Nervous breakdowns usually result when people work too hard.

Strongly Agree   Moderately Agree   Slightly Agree   Slightly Disagree   Moderately Disagree   Strongly Disagree

11. The patients of a mental hospital should have something to say about the way a hospital is run.

Strongly Agree   Moderately Agree   Slightly Agree   Slightly Disagree   Moderately Disagree   Strongly Disagree

12. Mental illness is usually caused by some disease of the nervous system.

Strongly Agree   Moderately Agree   Slightly Agree   Slightly Disagree   Moderately Disagree   Strongly Disagree

13. All patients in mental hospitals should be prevented from having children by a painless operation.

Strongly Agree   Moderately Agree   Slightly Agree   Slightly Disagree   Moderately Disagree   Strongly Disagree

14. The small children of patients in mental hospitals should not be allowed to visit them

Strongly Agree   Moderately Agree   Slightly Agree   Slightly Disagree   Moderately Disagree   Strongly Disagree

15. Mental illness is an illness like any other.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

16. It is easy to recognize someone who had a serious mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

17. Most mental patients are willing to work.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

18. Regardless of how you look at it, patients with severe mental illness are no longer really human.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

19. Many people who have never been patients in a mental hospital are more mentally ill than many hospitalized mental patients.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

20. There is something about mental patients that makes it easy to tell them from normal people.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

21. If people would talk less and work more, everybody would be better off.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

22. Even though patients in mental hospitals behave in funny ways, it is wrong to laugh at them.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

23. People with mental illness should never be treated in the same hospital as people with physical illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

24. A person who has bad manners, habits, and breeding can hardly expect to get along with decent people.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

25. If the children of normal parents were raised by mentally ill parents, they would probably become mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

26. A heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

27. To become a patient in a mental hospital is to become a failure in life.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

28. Patients in mental hospitals are in many ways like children.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

29. More tax money should be spent in the care and treatment of people with severe mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

30. Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

31. A woman would be foolish to marry a man who has had a severe mental illness, even though he seems fully recovered.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

32. Anyone who tries hard to better himself deserves the respect of others.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

33. Our mental hospitals seem more like prisons than like places where mentally ill people can be cared for.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

34. People who have been patients in a mental hospital will never be their old selves again.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

35. If our hospitals had enough well trained doctors, nurses, and aides, many of the patients would get well enough to live outside the hospital.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

36. The law should allow a woman to divorce her husband as soon as he has been confined in a mental hospital with a severe mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

37. The best way to handle patients in mental hospitals is to keep them behind locked doors.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

38. Many patients in mental hospitals make wholesome friendships with other patients.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

39. Although patients discharged from mental hospitals may seem all right, they should not be allowed to marry.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

40. Many mental patients are capable of skilled labor, even though in some ways they are very disturbed mentally.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

41. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

42. Many mental patients would remain in the hospital until they were well, even if the doors were unlocked.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

43. Anyone who is in a hospital for a mental illness should not be allowed to vote.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

44. Every mental hospital should be surrounded by a high fence and guards.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

45. Every person should make a strong attempt to raise his social position.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

46. Most women who were once patients in a mental hospital could be trusted as baby sitters.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

47. Most patients in mental hospitals don't care how they look.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

48. Obedience and respect for authority are the most important virtues children should learn.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

49. College professors are more likely to become mentally ill than are business men.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

50. People who are successful in their work seldom become mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

51. There is hardly anything lower than a person who does not feel a great love, gratitude and respect for his parents.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

52. The death penalty is inhuman and should be abolished.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

53. Every person should have complete faith in some supernatural power whose decisions he obeys without question.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

APPENDIX D

OPINIONS ABOUT MENTAL ILLNESS BENEVOLENCE FACTOR

NAME:________________________

DATE:________________________

AGENCY:______________________

OPINIONS ABOUT MENTAL ILLNESS

Read the following statements and decide whether you strongly agree, moderately agree, slightly agree, slightly disagree, moderately disagree, or strongly disagree with each. Circle the words which best describe how you feel. Be careful not to skip any statements.

1. If parents loved their children more, there would be less mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

2. One of the main causes of mental illness is a lack of moral strength or will power.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

3. Mental patients come from homes where the parents took little interest in their children.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

4. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everday life.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree	
7	6	5	3	2	1	Points

5. The mental illness of many people is caused by the separation or divorce of their parents during childhood.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

6. People would not become mentally ill if they avoided bad thoughts.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

7. People who are mentally ill let their emotions control them; normal people think things out.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

8. If the children of mentally ill parents were raised by normal parents, they would probably not become mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

9. When a person has a problem or worry, it is best not to think about it, but keep busy with more pleasant things.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

10. Nervous breakdowns usually result when people work too hard.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

11. The patients of a mental hospital should have something to say about the way a hospital is run.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

12. Mental illness is usually caused by some disease of the nervous system.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

13. All patients in mental hospitals should be prevented from having children by a painless operation.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

14. The small children of patients in mental hospitals should not be allowed to visit them

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

15. Mental illness is an illness like any other.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

16. It is easy to recognize someone who had a serious mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

17. Most mental patients are willing to work.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

18. Regardless of how you look at it, patients with severe mental illness are no longer really human.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

19. Many people who have never beed patients in a mental hospital are more mentally ill than many hospitalized mental patients.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

20. There is something about mental patients that makes it easy to tell them from normal people.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

21. If people would talk less and work more, everybody would be better off.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

22. Even though patients in mental hospitals behave in funny ways, it is wrong to laugh at them.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

23. People with mental illness should never be treated in the same hospital as people with physical illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

24. A person who has bad manners, habits, and breeding can hardly expect to get along with decent people.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

25. If the children of normal parents were raised by mentally ill parents, they would probably become mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

26. A heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

27. To become a patient in a mental hospital is to become a failure in life.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
1	2	3	5	6	7

28. Patients in mental hospitals are in many ways like children.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

29. More tax money should be spent in the care and treatment of people with severe mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

30. Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

31. A woman would be foolish to marry a man who has had a severe mental illness, even though he seems fully recovered.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

32. Anyone who tries hard to better himself deserves the respect of others.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

33. Our mental hospitals seem more like prisons than like places where mentally ill people can be cared for.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
1	2	3	5	6	7

34. People who have been patients in a mental hospital will never be their old selves again.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

35. If our hospitals had enough well trained doctors, nurses, and aides, many of the patients would get well enough to live outside the hospital.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

36. The law should allow a woman to divorce her husband as soon as he has been confined in a mental hospital with a severe mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

37. The best way to handle patients in mental hospitals is to keep them behind locked doors.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

38. Many patients in mental hospitals make wholesome friendships with other patients.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

39. Although patients discharged from mental hospitals may seem all right, they should not be allowed to marry.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

40. Many mental patients are capable of skilled labor, even though in some ways they are very disturbed mentally.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

41. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
1	2	3	5	6	7

42. Many mental patients would remain in the hospital until they were well, even if the doors were unlocked.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

43. Anyone who is in a hospital for a mental illness should not be allowed to vote.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

44. Every mental hospital should be surrounded by a high fence and guards.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

45. Every person should make a strong attempt to raise his social position.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

46. Most women who were once patients in a mental hospital could be trusted as baby sitters.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

47. Most patients in mental hospitals don't care how they look.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

48. Obedience and respect for authority are the most important virtues children should learn.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

49. College professors are more likely to become mentally ill than are business men.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

50. People who are successful in their work seldom become mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

51. There is hardly anything lower than a person who does not feel a great love, gratitude and respect for his parents.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

52. The death penalty is inhuman and should be abolished.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

53. Every person should have complete faith in some supernatural power whose decisions he obeys without question.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

NOTE: Higher scores reflect greater benevolence

APPENDIX E

OPINIONS ABOUT MENTAL ILLNESS
MENTAL HYGIENE IDEOLOGY FACTOR

NAME: ____________________

DATE: ____________________

AGENCY: ____________________

OPINIONS ABOUT MENTAL ILLNESS

Read the following statements and decide whether you strongly agree, moderately agree, slightly agree, slightly disagree, moderately disagree, or strongly disagree with each. Circle the words which best describe how you feel. Be careful not to skip any statements.

1. If parents loved their children more, there would be less mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

2. One of the main causes of mental illness is a lack of moral strength or will power.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

3. Mental patients come from homes where the parents took little interest in their children.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

4. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everday life.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

5. The mental illness of many people is caused by the separation or divorce of their parents during childhood.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

6. People would not become mentally ill if they avoided bad thoughts.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

7. People who are mentally ill let their emotions control them; normal people think things out.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

8. If the children of mentally ill parents were raised by normal parents, they would probably not become mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

9. When a person has a problem or worry, it is best not to think about it, but keep busy with more pleasant things.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

10. Nervous breakdowns usually result when people work too hard.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

11. The patients of a mental hospital should have something to say about the way a hospital is run.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree	
7	6	5	3	2	1	Points

12. Mental illness is usually caused by some disease of the nervous system.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

13. All patients in mental hospitals should be prevented from having children by a painless operation.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

14. The small children of patients in mental hospitals should not be allowed to visit them

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

15. Mental illness is an illness like any other.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

16. It is easy to recognize someone who had a serious mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

17. Most mental patients are willing to work.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	[illegible]	[illegible]	[illegible]	[illegible]

18. Regardless of how [illegible] are no longer real [illegible]

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

19. Many people who have never been patients in a mental hospital are more mentally ill than many hospitalized mental patients.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

20. There is something about mental patients that makes it easy to tell them from normal people.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

21. If people would talk less and work more, everybody would be better off.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

22. Even though patients in mental hospitals behave in funny ways, it is wrong to laugh at them.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

23. People with mental illness should never be treated in the same hospital as people with physical illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

24. A person who has bad manners, habits, and breeding can hardly expect to get along with decent people.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

25. If the children of normal parents were raised by mentally ill parents, they would probably become mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

26. A heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

27. To become a patient in a mental hospital is to become a failure in life.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

28. Patients in mental hospitals are in many ways like children.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

29. More tax money should be spent in the care and treatment of people with severe mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

30. Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

31. A woman would be foolish to marry a man who has had a severe mental illness, even though he seems fully recovered.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

32. Anyone who tries hard to better himself deserves the respect of others.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

33. Our mental hospitals seem more like prisons than like places where mentally ill people can be cared for.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

34. [illegible]

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

35. If our hospitals had enough well trained doctors, nurses, and aides, many of the patients would get well enough to live outside the hospital.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

36. The law should allow a woman to divorce her husband as soon as he has been confined in a mental hospital with a severe mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

37. The best way to handle patients in mental hospitals is to keep them behind locked doors.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

38. Many patients in mental hospitals make wholesome friendships with other patients.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

39. Although patients discharged from mental hospitals may seem all right, they should not be allowed to marry.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

40. Many mental patients are capable of skilled labor, even though in some ways they are very disturbed mentally.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

41. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

42. Many mental patients would remain in the hospital until they were well, even if the doors were unlocked.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

43. Anyone who is in a hospital for a mental illness should not be allowed to vote.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

44. Every mental hospital should be surrounded by a high fence and guards.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

45. Every person should make a strong attempt to raise his social position.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

46. Most women who were once patients in a mental hospital could be trusted as baby sitters.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

47. Most patients in mental hospitals don't care how they look.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

48. Obedience and respect for authority are the most important virtues children should learn.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

49. College professors are more likely to become mentally ill than are business men.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

50. People who are successful in their work seldom become mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

51. There is hardly anything lower than a person who does not feel a great love, gratitude and respect for his parents.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

52. The death penalty is inhuman and should be abolished.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

53. Every person should have complete faith in some supernatural power whose decisions he obeys without question.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

NOTE: Higher scores reflect greater Mental Hygiene Ideology

APPENDIX F

OPINIONS ABOUT MENTAL ILLNESS SOCIAL RESTRICTIVENESS FACTOR

NAME:______________________

DATE:______________________

AGENCY:____________________

OPINIONS ABOUT MENTAL ILLNESS

Read the following statements and decide whether you strongly agree, moderately agree, slightly agree, slightly disagree, moderately disagree, or strongly disagree with each. Circle the words which best describe how you feel. Be careful not to skip any statements.

1. If parents loved their children more, there would be less mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

2. One of the main causes of mental illness is a lack of moral strength or will power.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

3. Mental patients come from homes where the parents took little interest in their children.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

4. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everday life.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

5. The mental illness of many people is caused by the separation or divorce of their parents during childhood.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

6. People would not become mentally ill if they avoided bad thoughts.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

7. People who are mentally ill let their emotions control them; normal people think things out.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

8. If the children of mentally ill parents were raised by normal parents, they would probably not become mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

9. When a person has a problem or worry, it is best not to think about it, but keep busy with more pleasant things.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

10. Nervous breakdowns usually result when people work too hard.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

11. The patients of a mental hospital should have something to say about the way a hospital is run.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

12. Mental illness is usually caused by some disease of the nervous system.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

13. All patients in mental hospitals should be prevented from having children by a painless operation.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

14. The small children of patients in mental hospitals should not be allowed to visit them

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

15. Mental illness is an illness like any other.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

16. It is easy to recognize someone who had a serious mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

17. Most mental patients are willing to work.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

18. Regardless of how you look at it, patients with severe mental illness are no longer really human.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

19. Many people who have never been patients in a mental hospital are more mentally ill than many hospitalized mental patients.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

20. There is something about mental patients that makes it easy to tell them from normal people.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

21. If people would talk less and work more, everybody would be better off.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

22. Even though patients in mental hospitals behave in funny ways, it is wrong to laugh at them.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

23. People with mental illness should never be treated in the same hospital as people with physical illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

24. A person who has bad manners, habits, and breeding can hardly expect to get along with decent people.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

25. If the children of normal parents were raised by mentally ill parents, they would probably become mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

26. A heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

27. To become a patient in a mental hospital is to become a failure in life.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

28. Patients in mental hospitals are in many ways like children.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

29. More tax money should be spent in the care and treatment of people with severe mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

30. Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

31. A woman would be foolish to marry a man who has had a severe mental illness, even though he seems fully recovered.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

32. Anyone who tries hard to better himself deserves the respect of others.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

33. Our mental hospitals seem more like prisons than like places where mentally ill people can be cared for.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

34. People who have been patients in a mental hospital will never be their old selves again.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

35. If our hospitals had enough well trained doctors, nurses, and aides, many of the patients would get well enough to live outside the hospital.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

36. The law should allow a woman to divorce her husband as soon as he has been confined in a mental hospital with a severe mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

37. The best way to handle patients in mental hospitals is to keep them behind locked doors.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

38. Many patients in mental hospitals make wholesome friendships with other patients.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
1	2	3	5	6	7

39. Although patients discharged from mental hospitals may seem all right, they should not be allowed to marry.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

40. Many mental patients are capable of skilled labor, even though in some ways they are very disturbed mentally.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

41. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

42. Many mental patients would remain in the hospital until they were well, even if the doors were unlocked.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

43. Anyone who is in a hospital for a mental illness should not be allowed to vote.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

44. Every mental hospital should be surrounded by a high fence and guards.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

45. Every person should make a strong attempt to raise his social position.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

46. Most women who were once patients in a mental hospital could be trusted as baby sitters.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
1	2	3	5	6	7

47. Most patients in mental hospitals don't care how they look.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

48. Obedience and respect for authority are the most important virtues children should learn.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

49. College professors are more likely to become mentally ill than are business men.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

50. People who are successful in their work seldom become mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

51. There is hardly anything lower than a person who does not feel a great love, gratitude and respect for his parents.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

52. The death penalty is inhuman and should be abolished.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

53. Every person should have complete faith in some supernatural power whose decisions he obeys without question.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

NOTE: Higher scores reflect greater social restrictiveness opinions

APPENDIX G

OPINIONS ABOUT MENTAL ILLNESS INTERPERSONAL ETIOLOGY FACTOR

NAME:________________________

DATE:________________________

AGENCY:______________________

OPINIONS ABOUT MENTAL ILLNESS

Read the following statements and decide whether you strongly agree, moderately agree, slightly agree, slightly disagree, moderately disagree, or strongly disagree with each. Circle the words which best describe how you feel. Be careful not to skip any statements.

1. If parents loved their children more, there would be less mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

2. One of the main causes of mental illness is a lack of moral strength or will power.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

3. Mental patients come from homes where the parents took little interest in their children.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

4. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everday life.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

5. The mental illness of many people is caused by the separation or divorce of their parents during childhood.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

6. People would not become mentally ill if they avoided bad thoughts.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

7. People who are mentally ill let their emotions control them; normal people think things out.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

8. If the children of mentally ill parents were raised by normal parents, they would probably not become mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

9. When a person has a problem or worry, it is best not to think about it, but keep busy with more pleasant things.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

10. Nervous breakdowns usually result when people work too hard.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

11. The patients of a mental hospital should have something to say about the way a hospital is run.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

12. Mental illness is usually caused by some disease of the nervous system.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

13. All patients in mental hospitals should be prevented from having children by a painless operation.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

14. The small children of patients in mental hospitals should not be allowed to visit them

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

15. Mental illness is an illness like any other.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

16. It is easy to recognize someone who had a serious mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

17. Most mental patients are willing to work.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

18. Regardless of how you look at it, patients with severe mental illness are no longer really human.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

19. Many people who have never been patients in a mental hospital are more mentally ill than many hospitalized mental patients.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

20. There is something about mental patients that makes it easy to tell them from normal people.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

21. If people would talk less and work more, everybody would be better off.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

22. Even though patients in mental hospitals behave in funny ways, it is wrong to laugh at them.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

23. People with mental illness should never be treated in the same hospital as people with physical illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

24. A person who has bad manners, habits, and breeding can hardly expect to get along with decent people.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

25. If the children of normal parents were raised by mentally ill parents, they would probably become mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

26. A heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

27. To become a patient in a mental hospital is to become a failure in life.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

28. Patients in mental hospitals are in many ways like children.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

29. More tax money should be spent in the care and treatment of people with severe mental illness.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

30. Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

32. [illegible]

Strongly Agree | Moderately Agree | Slightly Agree | Slightly Disagree | Moderately Disagree | Strongly Disagree

33. Our mental hospitals seem more like prisons than like places where mentally ill people can be cared for.

Strongly Agree | Moderately Agree | Slightly Agree | Slightly Disagree | Moderately Disagree | Strongly Disagree

34. People who have been patients in a mental hospital will never be their old selves again.

Strongly Agree | Moderately Agree | Slightly Agree | Slightly Disagree | Moderately Disagree | Strongly Disagree

35. If our hospitals had enough well trained doctors, nurses, and aides, many of the patients would get well enough to live outside the hospital.

Strongly Agree | Moderately Agree | Slightly Agree | Slightly Disagree | Moderately Disagree | Strongly Disagree

36. The law should allow a woman to divorce her husband as soon as he has been confined in a mental hospital with a severe mental illness.

Strongly Agree | Moderately Agree | Slightly Agree | Slightly Disagree | Moderately Disagree | Strongly Disagree

37. The best way to handle patients in mental hospitals is to keep them behind locked doors.

Strongly Agree | Moderately Agree | Slightly Agree | Slightly Disagree | Moderately Disagree | Strongly Disagree

38. Many patients in mental hospitals make wholesome friendships with other patients.

Strongly Agree | Moderately Agree | Slightly Agree | Slightly Disagree | Moderately Disagree | Strongly Disagree

39. Although patients discharged from mental hospitals may seem all right, they should not be allowed to marry.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

40. Many mental patients are capable of skilled labor, even though in some ways they are very disturbed mentally.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

41. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

42. Many mental patients would remain in the hospital until they were well, even if the doors were unlocked.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

43. Anyone who is in a hospital for a mental illness should not be allowed to vote.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

44. Every mental hospital should be surrounded by a high fence and guards.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

45. Every person should make a strong attempt to raise his social position.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

46. Most women who were once patients in a mental hospital could be trusted as baby sitters.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

47. Most patients in mental hospitals don't care how they look.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

48. Obedience and respect for authority are the most important virtues children should learn.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

49. College professors are more likely to become mentally ill than are business men.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

50. People who are successful in their work seldom become mentally ill.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
7	6	5	3	2	1

51. There is hardly anything lower than a person who does not feel a great love, gratitude and respect for his parents.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

52. The death penalty is inhuman and should be abolished.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

53. Every person should have complete faith in some supernatural power whose decisions he obeys without question.

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree

NOTE: Higher scores reflect greater Interpersonal Etiology Opinions

APPENDIX H

CARKHUFF SCALES
FORM A
FORM B

INSTRUCTIONS

You will read about (listen to) eight persons who are seeking help with a problem. They may not be normal clients but simply people who have sought the help of another person in a time of need.

Following each excerpt by a person seeking help you will read (listen to) four possible responses. These are initial responses which might be made early in the course of the helping relationship. Each of the four responses should be rated according to the continuum below. Rate each response independently of the others.

Rate each response 1.0, 1.5, 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, or 5.0.

1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0
Is not helpful in recognizing the problem; may hinder communication		Partial recognition of problem and/or feelings towards it.		Minimally helps the person in recognizing the problem and his feelings towards it.		Significantly helps the person in recognizing the problem and dealing with it.		Optimally aids the person in dealing with his problem.

As you judge the responses, keep in mind that most highly rated responses are those which the person can use most effectively in his present situation.

FORM A

EXCERPT 1

HELPEE: I don't know if I am right or wrong feeling the way I do. But I find myself withdrawing from people. I don't seem to socialize and play their stupid little games any more. I get upset and come home depressed and have headaches. It all seems so superficial. There was a time when I used to get along with everybody. Everybody said, "Isn't she wonderful. She gets along with everybody. Everybody likes her." I used to think that was something to be really proud of, but that was who I was at that time. I had no depth. I was what the crowd wanted me to be-- the particular group I was with.

HELPER RESPONSES:

____ (1) You know you have changeda lot. There are a lot of things you want to do but no longer can.

____ (2) You are damned sure who you can't be any longer but you are not sure who you are. Still hesitant as to who you are yet.

____ (3) Who are these people that make you so angry? Why don't you tell them where to get off! They can't control your existence. You have to be your own person.

____ (4) So you have a social problem involving interpersonal difficulties with others.

EXCERPT 2

HELPEE: I love my children and my husband and I like doing most household things. They get boring at times but on the whole, I think it can be very rewarding at times. I don't miss working, going to the office every day. Most women complain of being just a housewife and just a mother. But, then again, I wonder if there is more for me. Others say there has to be. I really don't know.

HELPER RESPONSES:

____ (1) Hmm. Who are these other people?

____ (2) So you find yourself raising a lot of questions about yourself-- educationally, vocationally.

____ (3) Why are you dominated by what others see for you? If you are comfortable and enjoy being a housewife, then continue in this job. The role of mother, homemaker can be a full-time, self-satisfying job.

____ (4) While others raise these questions, these questions are real for you. You don't know if there is more there for you. You don't know if you can find more fulfillment than you have.

EXCERPT 3

HELPEE: Sometimes I question my adequacy of raising three boys, especially the baby. I call him the baby--well, he is the last. I can't have any more. So I know I kept him a baby longer than the others. He won't let anyone else do things for him. If someone else opens the door, he says he wants Mommy to do it. I encourage this. I do it. I don't know if this is right or wrong. He insists on sleeping with me every night and I allow it. And he says when he grows up he won't do it any more. Right now he is my baby and I don't discourage this much. I don't know if this comes out of my needs or if I'm making too much out of the situation or if this will handicap him when he goes to school--breaking away from Mamma. Is it going to be a traumatic experience for him? Is it something I'm creating for him? I do worry more about my children than I think most mothers do.

HELPER RESPONSES:

____ (1) So you find yourself raising a lot of questions as to if what you are doing is right for your child.

____ (2) Is it perhaps possible for you to have the child become involved in a situation such as some experiences in a public park where the child could play and perhaps at a distance you could supervise --where the child can gain some independence?

____ (3) Could you tell me--have you talked to your husband about this?

____ (4) While you are raising a lot of questions for yourself about yourself in relation to your youngest child, you are raising some more basic questions about yourself in relation to you. In lots of ways you're not certain where you are going--not sure who you are.

EXCERPT 4

HELPEE: It's not an easy thing to talk about. I guess the heart of the problem is sort of a sexual problem. I never thought I would have this sort of problem. But I find myself not getting the fulfillment I used to. It's not as enjoyable--for my husband either, although we don't discuss it. I used to enjoy and look forward to making love. I used to have an orgasm but I don't anymore. I can't remember the last time I was satisfied. I find myself being attracted to other men and wondering what it would be like to go to bed with them. I don't know what this means. Is this symptomatic of our whole relationship as a marriage? Is something wrong with me or us?

HELPER RESPONSES:

____ (1) Perhaps you feel your marriage and role of mother is holding you back and preventing you from being something else you want to be. Your resentment here against your husband is manifested in your frigidity. Perhaps it is your way of paying him back for keeping you down.

____ (2) What about your relationship with your husband, his role as father and companion?

____ (3) You don't quite know what to make of all this but you know something is dreadfully wrong and you are determined to find out for yourself, for your marriage.

____ (4) What's happened between you and your husband has raised a lot of questions about you, about him, and about your marriage.

EXCERPT 5

HELPEE: Gee, those people! Who do they think they are? I just can't stand interacting with them anymore. Just a bunch of phonies. They leave me so frustrated. They make me so anxious, I get angry at myself. I don't even want to be bothered with them anymore. I just wish I could be honest with them and tell them all to go to hell! But I guess I just can't do it.

HELPER RESPONSES:

____ (1) They really make you very angry. You wish you could handle them more effectively than you do.

____ (2) Damn, they make you furious! But it's not just them. It's with yourself, too, because you don't act on how you feel.

____ (3) Why do you feel these people are phony? What do they say to you?

____ (4) Maybe society itself is at fault here--making you feel inadequate, giving you this negative view of yourself, leading you to be unable to successfully interact with others.

EXCERPT 6

HELPEE: They wave that degree up like it's a pot of gold at the end of the rainbow. I used to think that, too, until I tried it. I'm happy being a housewife; I don't care to get a degree. But the people I associate with, the first thing they say is, "Where did you get your degree?" I answer, "I don't have a degree." Christ, they look at you like you are some sort of a freak, some backwoodsman your husband picked up along the way. They actually believe that people with degrees are better. In fact, I think they are worse. I've found a lot of people without degrees that are a hell of a lot smarter than these people. They think just because they have degrees they are something special. These poor kids that think they have to go to college or they are ruined. It seems that we are trying to perpetuate a fraud on these kids. If no degree, they think they will end up digging ditches the rest of their lives. They are looked down upon. That makes me sick.

HELPER RESPONSES:

____ (1) You really resent having to meet the goals other people set for you.

____ (2) What do you mean by "it makes me sick?"

____ (3) Do you honestly feel a degree makes a person worse or better? And not having a degree makes you better? Do you realize society perpetuates many frauds and sets many prerequisites such as a degree. You must realize how doors are closed unless you have a degree, while the ditches are certainly open.

____ (4) A lot of these expectations make you furious. Yet, they do tap in on something in yourself you are not sure of--something about yourself in relation to these other people.

EXCERPT 7

HELPEE: I get so frustrated and furious with my daughter. I just don't know what to do with her. She is bright and sensitive, but damn, she has some characteristics that make me so on edge. I can't handle it sometimes. She just--I feel myself getting more and more angry! She won't do what you tell her to. She tests limits like mad. I scream and yell and lose control and think there is something wrong with me--I'm not an understanding mother or something. Damn! What potential! What she could do with what she has. There are times she doesn't use what she's got. She gets by too cheaply. I just don't know what to do with her. Then she can be so nice and then, boy, she can be as onery as she can be. And then I scream and yell and I'm about ready to slam her across the room. I don't like to feel this way. I don't know what to do with it.

HELPER RESPONSES:

____ (1) So you find yourself screaming and yelling at your daughter more frequently during the past three months.

____ (2) Why don't you try giving your daughter some very precise limitations. Tell her what you expect from her and what you don't expect from her. No excuses.

____ (3) While she frustrates the hell out of you, what you are really asking is, "How can I help her? How can I help myself, particularly in relation to this kid?"

____ (4) While she makes you very angry, you really care what happens to her.

EXCERPT 8

HELPEE: I'm so thrilled to have found a counselor like you. I didn't know any existed. You seem to understand me so well. It's just great! I feel like I'm coming alive again. I have not felt like this in so long.

HELPER RESPONSES:

____ (1) Gratitude is a natural emotion.

____ (2) This is quite nice but remember, unless extreme caution is exercised, you may find yourself moving in the other direction.

____ (3) That's a good feeling.

____ (4) Hey, I'm as thrilled to hear you talk this way as you are! I'm pleased that I have been helpful. I do think we still have some work to do yet, though.

FORM B

EXCERPT 1

HELPEE: He is ridiculous! Everything has to be done when he wants to do it. The way he wants it done. It's as if nobody else exists. It's everything he wants to do. There is a range of things I have to do. Not just be a housewife and take care of the kids. Oh no, I have to do his typing for him, errands for him. If I don't do it right away, I'm stupid--I'm not a good wife or something stupid like that. I have an identity of my own and I'm not going to have it wrapped up in him. It makes me--it infuriates me! I want to punch him right in the mouth. What am I going to do? Who does he think he is, anyway?

HELPER RESPONSES:

(1) It really angers you when you realize in how many ways he has taken advantage of you.

(2) Tell me, what is your concept of a good marriage?

(3) Your husband makes you feel inferior in your own eyes. You feel incompetent. In many ways you make him sound like a very cruel and destructive man.

(4) It makes you furious when you think of the one-sidedness of this relationship. He imposes upon you everywhere, particularly in your own struggle for your own identity. And you don't know where this relationship is going.

EXCERPT 2

HELPEE: I finally found somebody I can really get along with. There is no pretentiousness about them at all. They are real and they understand me. I can be myself with them. I don't worry about what I say and that they might take me wrong, because I do sometimes say things that don't come out the way that I want them to. I don't have to worry that they are going to criticize me. They are just marvelous people! I just can't wait to be with them. For once I actually enjoy going out and interacting. I didn't think I could ever find people like this again. I can really be myself. It's such a wonderful feeling not to have people criticizing you for everything you say that doesn't agree with them. They are warm and understanding and I just love them! It's just marvelous.

HELPER RESPONSES:

(1) Sound like you found someone who really matters to you.

(2) Why do these kind of people accept you?

(3) That's a real good feeling to have someone to trust and share with. "Finally, I can be myself."

(4) Now that you have found these people who enjoy you and whom you enjoy, spend your time with these people. Forget about the other types who make you anxious. Spend your time with the people who can understand and be warm with you.

EXCERPT 3

HELPEE: I'm really excited! We are going to California. I'm going to have a second lease on life. I found a marvelous job. It's great! It's so great I can't believe it's true--it's so great! I have a secreterial job. I can be a mother and can have a part-time job which I think I will enjoy very much. I can be home when the kids get home from school. It's too good to be true. It's so exciting. New horizons are unfolding. I just can't wait to get started. It's great!

HELPER RESPONSES:

(1) Don't you think you are biting off a little more than you can chew? Don't you think that working and taking care of the children will be a little bit too much? How does your husband feel about this?

(2) Hey, that's a might good feeling. You are on your way now. Even though there are some things you don't know along the way, it's just exciting to be gone.

(3) Let me caution you to be cautious in your judgment. Don't be too hasty. Try to get settled first.

(4) It's a good feeling to contemplate doing these things.

EXCERPT 4

HELPEE: I'm so pleased with the kids. They are doing just marvelously. They have done so well at school and at home; they get along together. It's amazing. I never thought they would. They seem a little older. They play together better and they enjoy each other, and I enjoy them. Life has become so much easier. It's really a joy to raise three boys. I didn't think it would be. I'm just so pleased and hopeful for the future. For them and for us. It's just great! I can't believe it. It's marvelous!

HELPER RESPONSES:

(1) It's a good feeling to have your kids settled once again.

(2) Is it possible your kids were happy before but you never noticed it before? You mentioned your boys. How about your husband? Is he happy?

(3) Do you feel this is a permanent change?

(4) Hey, that's great! Whatever the problem, and you know there will be problems, it's great to have experienced the positive side of it.

EXCERPT 5

HELPEE: Silence. (Moving about in chair)

HELPER RESPONSES:

(1) You can't really say all that you feel at this moment.

(2) A penny for your thoughts.

(3) Are you nervous? Maybe you haven't made the progress we hoped for.

(4) You just don't know what to say at this moment.

EXCERPT 6

HELPEE: I'm really excited the way things are going at home with my husband. It's just amazing! We get along great together now. Sexually, I didn't know we could be that happy. I didn't know anyone could be that happy. It's just marvelous! I'm just so pleased, I don't know what else to say.

HELPER RESPONSES:

(1) It's a wonderful feeling when things are going well maritally.

(2) It's really exciting to be alive again, to feel your boy again, to be in love again.

(3) Is your husband aware of these changes?

(4) Now don't go overboard on this right now. There will be problems that lie ahead and during these periods that you have these problems I want you to remember well the bliss you experienced in this moment in time.

EXCERPT 7

HELPEE: Gee, I'm so disappointed. I thought we could get along together and you could help me. We don't seem to be getting anywhere. You don't understand me. You don't know I'm here. I don't even think you care for me. You don't hear me when I talk. You seem to be somewhere else. Your responses are independent of anything I have to say. I don't know where to turn. I'm just so--doggone it--I don't know what I'm going to do, but I know you can't help me. There just is no hope.

HELPER RESPONSES:

(1) I have no reason to try and not to help you. I have every reason to want to help you.

(2) Only when we establish mutual understanding and trust and only then can we proceed to work on your problem effectively.

(3) It's disappointing and disillusioning to think you have made so little progress.

(4) I feel badly that you feel that way. I do want to help. I'm wondering, "Is it me? Is it you, both of us? Can we work something out?"

EXCERPT 8

HELPEE: Who do you think you are? You call yourself a therapist! Damn, here I am spilling my guts out and all you do is look at the clock. You don't hear what I say. Your responses are not attuned to what I'm saying. I never heard of such therapy. You are supposed to be helping me. You are so wrapped up in your world you don't hear a thing I'm saying. You don't give me the time. The minute the hour is up you push me out the door whether I have something important to say or not. I--uh--it makes me so goddamn mad!

HELPER RESPONSES:

(1) You are suggesting I'm wrapped up in myself. Do you think that perhaps, in fact, this is your problem?

(2) I'm only trying to listen to you. Really, I think we are making a whole lot of progress here.

(3) You are pretty displeased with what has been going on here.

(4) All right, you are furious, but I wonder if it's all mine or is there something else eating at you.

NAME:

DATE:

FORM:

RATING SHEET

EXCERPT 1

HELPER RESPONSES:

1.
2.
3.
4.

EXCERPT 2

HELPER RESPONSES:

1.
2.
3.
4.

EXCERPT 3

HELPER RESPONSES:

1.
2.
3.
4.

EXCERPT 4

HELPER RESPONSES:

1.
2.
3.
4.

EXCERPT 5

HELPER RESPONSES:

1.
2.
3.
4.

EXCERPT 6

HELPER RESPONSES:

1.
2.
3.
4.

EXCERPT 7

HELPER RESPONSES:

1.
2.
3.
4.

EXCERPT 8

HELPER RESPONSES:

1.
2.
3.
4.

APPENDIX I

COUNSELING SKILLS EVALUATION

RESPONSE SHEET

In a moment you will be shown a video tape of short statements by various individuals whom you might imagine to be potential clients with whom you will be working. Following each segment, the film will be stopped and you will be asked to write in one or two sentences, what you might immediately say to this individual in response to their comments. Make your answers brief; also write so that your works are readable. Try to respond as you would naturally. The first few words of each segment are presented in parentheses following the segment number so that you will be sure to write your answer in the proper place.

Segment:

1. (Yes, I know what . . .) ____________________

2. (It's hard for me . . .) ____________________

3. (I guess I have been having trouble . . .) ____________________

4. (You know, my friends say . . .) ____________________

5. (Well, actually none of the kids . . .) ____________________

6. (I don't want to take math . . .)

7. (My job was absolutely boring . . .)

8. (The other day I just had it . . .)

9. (Well, he comes home drunk . . .)

10. (So I guess that means . . .)

11. (. . . a lot of little things . . .)

12. (There are some people . . .)

13. (It just seems that . . .)

14. (It's that damned bitch . . .)

15. (You've been so very kind . . .)

16. (Well, I'm not one of those women . . .)

17. (Well, I've thought of leaving him . . .)

18. (Well, in the other school . . .)

19. (In your class, too, . . .)

20. (Hmm . . . well, I guess this is just one more . . .) ________________

____

____

____

21. (I told my husband . . .) ________________________________

____

____

____

22. (We left the southwest . . .) ____________________________

____

____

23. (What I want . . . most of anything . . . ____________________

____

____

____

APPENDIX J

"WHO DID WHAT TO WHOM" ANSWER SHEET

"WHO DID WHAT TO WHOM"

1.
2.
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25.

APPENDIX K

KAGAN COUNSELOR VERBAL RESPONSE SCALE RATING SHEET

I need your help. I am giving special training to workers at many agencies in Savannah. This person is in our training class. We hope our training helps this worker give the best possible service to you. You can tell us how well we are doing. Please answer the following questions. We do not want the worker's name or your name on this paper. After you answer the questions, mail me your answers in the envelope. My address and and a stamp are on the envelope. Please send this as soon as you can. This way we can improve the training we give. Thank you for your help.

PLEASE CIRCLE YOUR ANSWER. SAY WHAT YOU FEEL.

1.	Was the person you talked to friendly and courteous?	YES	MAYBE	NO
2.	Did this person spend enough time with you?	YES	MAYBE	NO
3.	Was this person a good listener?	YES	MAYBE	NO
4.	Did the person know enough about you to help?	YES	MAYBE	NO
5.	Does the person plan to help you again soon?	YES	MAYBE	NO
6.	Do you feel like you need to see them again?	YES	MAYBE	NO
7.	Would you rather see someone else from the agency?	YES	MAYBE	NO
8.	Did you feel better after talking to this person?	YES	MAYBE	NO
9.	Did they help you find a solution to the problem?	YES	MAYBE	NO
10.	Did they solve your problem for you?	YES	MAYBE	NO
11.	Did they send you to someone else for help?	YES	MAYBE	NO
12.	If so, do you think this was the best thing to do?	YES	MAYBE	NO
13.	Would you want this same person to help you again?	YES	MAYBE	NO

CIRCLE THE MONTH AND THE DAY YOU HANDED OUT THE QUESTIONS

JAN FEB MAR APR MAY
JUN JUL AUG SEP

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26

27 28 29 30 31

HANDOUT 1

Counselor Verbal Response Scale
Rating Sheet

EXPLORATORY	NON-EXPLORATORY	AFFECTIVE	COGNITIVE	LISTENING	NON-LISTENING	HONEST LABELING	DISTORTED
1.							
2.							
3.							
.							
5.							
6.							
7.							
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APPENDIX L

POST SESSION EVALUATION

POST SESSION EVALUATION

Do not put your name on this!
Be frank and honest!

Date ____________________

1. How much did you like this session? (Circle one number)

Not at all		somewhat		very much
1	2	3	4	5

2. How much did you participate in this session

Not at all				very much
1	2	3	4	5

3. How much did this session help you in dealing with your clients?

Not helpful		Moderately helpful		Very helpful
1	2	3	4	5

4. What did you like most about this session? ____________________

____

5. What did you like the least about this session? ____________________

____

6. Rate each of the following components on both scales according to how helpful they were and how much you liked them. Place a number between 1 and 5 in the helpful and like brackets.

COMPONENT	CONTENT					PRESENTATION				
	Not Helpful		Moderately		Very Helpful	Did not like at all		Liked somewhat		Liked very much
	1	2	3	4	5	1	2	3	4	5

	Helpful	Like
1. ____________________	( )	( )
2. ____________________	( )	( )
3. ____________________	( )	( )
4. ____________________	( )	( )
5. ____________________	( )	( )
6. ____________________	( )	( )

7. Please comment on back on what you thought of this session.

APPENDIX M

CLIENT SOCIAL HISTORY BLANK

SYMPTOM CHECKLIST

LOG-1

LOG-2

CLIENT REPLY BLANK

CLIENT SOCIAL HISTORY BLANK

The categories of each biographical variable and their order from low to high follows below. Circle the appropriate score below each variable.

1. Age

	24 years of less	25-34	35-44	45 years and over
Circle:	25	50	75	100

2. Intelligence

	0-70	71-77	78-84	85-115	116-124	125, over
Circle:	8	25	41	58	75	92

3. Education

	None or some grades	Finished grade school	some high school	finished high school	some college, art school, business college	finished college or more
Circle:	8	25	41	58	75	92

4. Occupation (Please Specify ________________________) based on The Dictionary of Occupational Titles (1949).

	unskilled	semiskilled or service	clerical or sales	skilled	professional and managerial
Circle:	10	30	50	70	90

5. Employment History:

	usually unemployed	seasonal, fluctuating, frequent shifts, part-time employment	regularly employed
Circle:	30	60	90

6. Marital Status

	Single	Separated, divorced	remarried, widowed	single, continuous marriage
Circle:	25	50	75	100

Symptom Checklist

Indicate those symptoms given in the description of a patient's behavior by the professional staff at the time of initial institutional contact, or in the description of behavior presented by referring agents as the primary reason for hospitalization.

_____ All addictions except drinking

_____ Amnesia

_____ Apathetic

_____ Assaultive

_____ Blackouts

_____ Bizarre ideas or delusions

_____ Bodily complaint

_____ Charged with murder

_____ Convulsions

_____ Depersonalization

_____ Doesn't eat

_____ Depressed

_____ Drinking

_____ Eats a lot

_____ Euphoria

_____ Feels going crazy

_____ Fear of own hostile impulses

_____ Feels perverted

_____ Homosexuality

_____ Insomnia

_____ Irresponsible behavior

_____ Lying

_____ Maniacal outbursts

_____ Memory impairment

_____ Mood swings

_____ Obsessions

_____ Perplexed

_____ Phobias

_____ Psychosomatic disorders

_____ Rape

_____ Robbery

_____ Sexual deviation, except homosexuality

_____ Sexual preoccupation

_____ Self-depreciatory

_____ Suicidal attempt

_____ Suicidal ideas

_____ Suspicious

_____ Feelings of sexual inadequacy

_____ Fire setting

_____ Headaches

_____ Hallucinations

_____ Temper outbursts

_____ Tense

_____ Threatens assault

_____ Withdrawn

_____ Compulsions

LOG-1

Your name: ______________________________

Employing agency: ________________________

Date: ___________________

Please complete this form following your initial meeting with a client for a particular problem. You will complete Log-2 after termination with this person for the same problem of issue. (Do not overlook any clients). Please answer all questions carefully.

Client's: Code number ________ Age ________ Sex ______ Income: ________

marital status: single _____ divorced____ widowed ____ separated ____

remarried ____ single continuous marriage ____

Client education: None or some grades _______; Finished grade school _______;

Some high school ____; Finished high school _____; Some college, art school, business college ____; Finished college or more ____.

Client occupation: ____

Unskilled ____; Semi-skilled or service ____; Clerical skilled or sales ____; Professional and managerial ____.

Employment history: Usually employed ____; Seasonal, fluctuating, frequent shifts, part time employment ____; regularly employed ____.

Client's area of residence: _______________________________________

Who initiated the contact (client, you, client's family, police, etc.)?

____

Where did the contact occur (your office, client's home, hospital, etc.)?

____

Nature of client's problem: _______________________________________

____

General plan for dealing with client's problem:

--- (a) Attempt to handle yourself

If you plan to handle yourself, briefly describe your plans at this time ______________________________

____

--- (b) Immediately refer the client to more appropriate agency

If you plan to refer, to what agency? _______________

____

Does this agency operate on a fee scale? _____________

____

If so, is it a sliding scale? ____________________

____

Estimate of the number of contacts required to handle problem yourself or to refer to another agency, which ever you have chosen: _____________

Number of times this client has been seen for past problem: __________

____

Other family members seen in the past or being seen at present at your agency:

Relation to Client	Number of Times
____________________	__________
____________________	__________
____________________	__________
____________________	__________
____________________	__________
____________________	__________

Has client sought help for this problem elsewhere? _______________

If so, where? __________________________________

If you referred this client to another agency or agencies, did these agencies help with the clients problem?

	Agency	Problem	Helped?
1.	________	________	Yes _____ No _____
2.	________	________	Yes _____ No _____
3.	________	________	Yes _____ No _____

Problems handled to your and client's satisfaction so far:

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________

APPENDIX N

The Continuing Education Unit

THE CONTINUING EDUCATION UNIT

Purposes

The continuing education unit (CEU) has been designed as a uniform unit of measurement to facilitate the accumulation and exchange of standardized information about individual participation in non credit continuing education. The CEU is applicable whether information is transmitted from one person to another, from one institution to another, from individual to organization, from employee to employer, from one area of the country to another, or from one time period to another. The CEU may be used for the quantitative measurement, recording reporting, accumulation, transfer and recognition of participation by adults in noncredit continuing education activities.

The CEU is intended to serve all interests in noncredit continuing education, whether public or private, and whether individual, institutional, organizational, governmental or societal. It can be used to measure all levels of noncredit continuing education without regard to age of participants, subject matter, program format or instructional methodology. The CEU permits the individual who desires additional educational experience to look to many sources of continuing education, to select from many formats common to the field while accumulating a uniform record available for future reference.

Specific Objectives

With the establishment and widespread use of the CEU as a uniform and nationally accepted unit of measurement applicable to noncredit continuing education the main objectives that can be fulfilled are:

1. To establish permanent records for individual participants for accumulating, updating and transferring information concerning noncredit continuing education experiences.
2. To provide a uniform system for accumulating data at the institutional or organizational level to assist in program planning and development and in administration and fiscal management.
3. To establish a national system of measurement to facilitate the collection of data on a national basis and provide valid statistical information necessary for legislative action and public policy determination relating to noncredit adult and continuing education activities.

Flexibility of CEU

Variety is one of the recognized strengths of noncredit continuing education. The CEU concept is designed to sustain that variety. The CEU is to be applied only after content, format and methodology have been determined. When applied in this manner, the CEU does not lead to stereotypes in terms of the program length, methods, or formats used in meeting educational objectives.

DEFINITION

> One continuing education unit is defined as: ten contact hours of participation...in an organized continuing education experience... under responsible sponsorship...capable direction...and qualified instruction.

Each element included in the definition of the continuing education unit is an integral part of the larger concept of developing an educational experience of sufficient merit to be documented in permanent form on the record of the individual participant.

Ten Contact Hours of Participation...

The contact hour is defined as a typical fifty-minute classroom instructional session, or its equivalent. Ten instructional contact hours are required for one

CEU. The number of instructional contact hours is readily determined in the formal classroom situation. In more inforaml formats, the director or coordinator of the program must exercise judgment in determining the equivalent number of instructional hours required to achieve the educational objectives. In still less structured activities, the director must determine whether or not the individual participation and educational benefits derived from a noncredit learning experience are of sufficient merit for CEU to be awarded.

In an Organized Continuing Education Experience...

An organized educational experience presumes there has been planning to meet a specific need. The essential elements of such planning include the determination of the program's educational objectives in terms of: (a) the clientele to be served; (b) the new skill or understanding to be realized through the content or subject matter to be covered; and (c) the program format and instructional methodology to be employed.

Adequate and properly responsive program planning requires interaction between administrative personnel of the sponsoring organization, the instructor or educational leaders responsible for the learning experience, and representatives from the clientele group to be served. Additional inputs into the planning process by knowledgeable and interested persons may further strengthen the educational enterprise.

Under Responsible Sponsorship...

The sponsoring organization that awards CEU may be an educational institution, a professional association or a business or governmental organization. The sponsor must assume administrative responsibility for the program. This responsibility includes the assignment of direct supervision of the activity to a professionally capable program director or educational administrator and the maintenance of a permanent record system. The reputation and organizational integrity of the sponsor are reflected in the quality of the educational experience which is presented.

Capable Direction...

The elements of capable direction include: (a) professional educational leadership in program planning and development; (b)selection of the most effective educational format for the intended purpose and objectives; (c) assignment of qualified instructional staff; (d) adequate program management and administration; and (e) the design and implementation of evaluation techniques applicable to both individual participants and the total program.

And Qualified Instruction

The development of a systematic process leading to specified educational objectives requires the selection of an instructional staff that has the following qualifications: (a) competence in the subject matter (may be evidenced by experience in which command of the subject matter is recognized by the individual's peers, by formal education or training, or by demonstrated knowledge through publication in professional journals or appropriate media); (b) ability to transmit the educational content to the participants; (c) understanding of the program objectives; and (d) knowledge and skill in the instructional methodology and learning processes to be employed.

The University of Georgia

hereby certifies that

has satisfactorily completed

Community Services Specialist Training Program
March 29, 1976

and this certificate is awarded in recognition of attendance and participation in this program.

Director, Georgia Center for Continuing Education

Directors of Training

APPENDIX O

Special Workshop Themes

During and for Phase III of Training

Phase III of the training project involved three hour, weekly meetings of the groups. The themes of these sessions developed from observations of the trainees in their client contacts, from daily logs which trainees maintained based on their client contacts, and from the expressed needs of the trainees with respect to the demands placed on them in their work situation. A partial, annotated list of themes for these sessions appears below.

I. Change in the Community (Approximately 6 hours)

This segment deals with the effect that change has on the people we work with in the community. This includes changes in values, in jobs, in family life, social expectations or pressures, etc. Emphasis is given to exploring how the concept of change can be used to better understand and to work with people in the community.

II. Accurate Perceptions (Approximately 2 hours)

Employing audio-visual and visual aids, trainees are asked to recall interpersonal scenes by listing the details about the persons and situations that appear in the scenes. Discussion of items on the lists is useful to understanding the extent to which personal values, expectations and sets (for example looking for the abnormal) affect what we see. Distorted perceptions are explored with respect to their influence on our responses to others. The distinction between observation and interpretation is made along with the importance of checking out with our clients how we interpret or explain their observed behavior.

III. Community Agency Contacts (Approximately 1½ hours each)

Representatives from public agencies are brought into sessions who have contacts with the trainees in the daily work of each group (e.g., Public Health Nurses, Department of Family and Children's Services - both from their service section and benefit's payments section). These representatives explain aspects of their various services. In a question-answer session that follows, representatives and trainees deal with the kinds of clients' problems in which they jointly may be involved. In addition to a discussion of what kinds of services for the particular needs of clients, the problems of who is eligible for services and how to arrange for services are explored. Previous occurrences of interactional difficulties between agencies also are brought up and worked through such that participants find this among the most valuable and interesting of themes.

IV. Referral of Clients (Approximately 3 hours and on Demand)

This presentation and discussion centers on referring clients to other resources agencies or professionals for services. The content includes (1) how to make referrals, (2) how to see that they are followed through on the part of clients and the referred agency, (3) how you go about knowing where to refer*, (4) how to refer, (5) when to refer, and related topics. (*Trainees each receive a published pamphlet that lists the community agencies or groups in Chatham County, a brief description of their services and costs if any. In addition, representatives of various agencies are invited to discuss their role and function in the community.) Subsequently and on a continuing basis, referrals are discussed and handled in the sessions or on the occasions that they arise.

Trainees are provided with the names, telephone numbers and locations of the Savannah training staff. They are encouraged to contact the staff for consultation should problems arise with respect to referrals or case management that needs attention more immediately than the weekly meetings. This is a regular feature of the continuing training program.

V. Conducting Community Meetings (Approximately 8 Hours)

This section is based on a model adopted from Ruth Cohen's Theme Centered Interactional Approach to Groups with a blending of Robert's Rules of Order (trainees are provided with copies of this text). The two of these are blended to give the community service worker a prespective of what makes a business meeting work and what gets in the way of its working. It is designed to give them some structure that they can use in conducting meetings by (1) helping them follow what happens in a meeting, (2) what happens to a motion in a meeting, (3) what is the standard order of business for a meeting, (4) how to go about advertising the meeting in an effective way, (5) how to locate an appropriate time, place and circumstance for group meetings, (6) how to go about setting up a meeting, and (7) what to take care of for a meeting. These questions are dealt with in an expermential setting.

VI. Irrational Thinking and Related Interventions (Approximately 4 hours)

The focus of this segment involves methods for intervening with the irrational thoughts and feelings of clients which for the most part are self-defeating or defeat the help-giving efforts of others. These include irrational opinions, beliefs, and expectancies that clients have about themselves, about other people (e.g., family, friends, future or current employers), or about the services offered by the community services worker. The content is adapted from the Rational Emotive Therapy approach of Albert Ellis as well as other cognitive therapy techniques. Trainees plan approaches in relation to the specific irrational beliefs that they encounter and specify in the earlier part of the meeting.

VII. Interpersonal Communication (Approximately 8 hours)

This segment covers interpersonal communication as adapted from Watzlawick, J. Haley, Don Jackson, Virginia Satir and others. The emphasis is on dyadic communication as it pertains to helper-helpee, marital, family relationships, etc. Training involves background information about interpersonal effectiveness. Ongoing interactions of trainees in dyads provide opportunity for observation and discussion of the implications.

VIII. Behavior Change Methods in the Community Setting (Approximately 8 hours)

This segment is geared to the use of community services workers in their help to adults and children within the community setting itself rather than in a treatment facility. Trainees receive preparation and supervision of casework in which they develop a program of treatment for a previously identified problem. Feedback about the effectiveness of their intervention also comes from systematic behavioral observation from baseline through termination of the treatment plan. This segment in part is based on Patterson's text Families: Applications of Social Learning to Family Life. Trainees receive personal copies of this manual.

IX. Values Clarification (Approximately 3 hours)

This segment is designed to increase the self-awareness of trainees with respect to their personal values and the potential influence of personal values in their helping role. These experiential exercises attempt to clarify the trainee's values on particular issues, to demonstrate the strength or intensity with which values are held and to exemplify the diversity or differences of values across trainees. Trainees were sub-grouped in order to examine and discuss the implications of their values with respect to helping individuals, families, couples, etc. with problems. These include pregancy-related problems, drug or alcohol related problems, sexual behavior-related problems, death or dying-related problems, marriage-related problems, sex-role related problems, financial aid related problems, etc. Sub-grouping is based on value assessment that indicate the direction and relative strength of values. Values include attitudes toward abortion, adoption, pre-marital sex, substance users or abusers, financial dependency, sex-role stereotypes, etc. This segment is not intended to challenge the values of trainees, but rather to alert trainees to the manifestations of values in their helping behavior.

X. Reinforcing Activities or Pleasant Events Assessment (Approximately 3 hours)

This segment is designed to increase the attention of trainees to events in the lives of individuals that affect what they do as well as how they feel and think. Trainees list in column #1, 25 specific events on the assessment grid. The events are to be those that they find to be enjoyable, pleasant or positive. In the remaining separate columns that are adjacent to the list, trainees check those activities that apply to the following parameters. In column #2, which events or activities usually cost less than $3.00 tc engage in? Column #3, which events usually require less than 5 minutes of planning? Column #4, which events usually are started or initiated by you? Column #4, in which events are you usually by yourself? Column #5, which events have you done within the past 3 months? Column #6, which events would you like to do more often? These are examples of kinds of parameters surrounding the occurrence of reinforcing or rewarding events that are specific to each individual. Trainees compare the frequencies of each column with the group average. On the basis of these comparisons, trainees discuss the implications of frequencies with respect to enjoyment or dissatisfaction with personal events. For example, a feeling of loneliness in their lives may relate a high proportion of pleasant events that they do alone rather than with others. Trainees also discussed the implications of this method with respect to their clients.

APPENDIX P

SUMMARY TABLES OF STATISTICAL ANALYSES

TABLE 2

Comparisons of Pre-Training Scores of Experimental and Control Groups

Response Measure	*t*-value	df	*p*
Exploratory Responses	0.56	10	> .05
Listening Responses	0.48	10	> .05
Affective Responses	2.33	10	< .05
Honest Labeling	1.17	10	> .05
Distorted Responses	2.83	10	< .05
Locus of Control	0.45	19	> .05
Community Mental Health Ideology Scale	.75	19	> .05
Opinions About Mental Illness	.11	19	> .05
Carkhuff Index of Discrimination	.52	22	> .05
Index of Discrimination Form A versus Form B	.01	22	> .05

TABLE 3

Summary of F-Values for Locus of Control

(A) X Pre-Post-Followup Trials

(B) Analyses of Variance on Five Mental Health Attitude Measures

Attitude Measures	A	df	B	df	A X B	df
Authoritarianism Year One	3.73+	1/10	.12	2/20	.30	2/20
Years One and Two	1.14	1/16	.89	2/32	.64	2/32
Benevolence Year One	.00	1/10	3.99*	2/20	2.06	2/20
Years One and Two	1.70	1/16	4.85*	2/32	1.20	2/32
Mental Hygiene Ideology Year One	.02	1/10	1.47	2/20	1.55	2/20
Years One and Two	.20	1/16	.18	2/32	1.85	2/32
Interpersonal Etiology Year One	.10	1/10	3.30+	2/20	.20	2/20
Years One and Two	.56	1/16	1.93	2/32	1.24	2/32
Community Mental Health Ideology Scale Year One	.03	1/10	1.41	2/20	4.86*	2/20
Years One and Two	.00	1/16	1.14	2/32	2.13	2/32

+$p < .10$
*$p < .05$
**$p < .01$

TABLE 4

Summary of *F*-Values for Locus of Control

(A) X Pre-Post Trials

(B) Analyses of Variance on Five Mental Health Attitude Measures

Attitude Measures	A	df	B	df	A X B	df
Authoritarianism Year One	NA		NA		NA	
Years One and Two	.30	1/24	1.12	1/24	.52	1/24
Benevolence Year One	NA		NA		NA	
Years One and Two	2.28	1/24	16.84**	1/24	.07	1/24
Mental Hygiene Ideology Year One	NA		NA		NA	
Years One and Two	3.73+	1/24	.07	1/24	.99	1/24
Interpersonal Etiology Year One	NA		NA		NA	
Years One and Two	.03	1/24	.07	1/24	.99	1/24
Community Mental Health Ideology Scale Year One	NA		NA		NA	
Years One and Two	2.90	1/26	.02	1/26	.63	1/26

+$p < .10$
*$p < .05$
**$p < .01$

TABLE 5

Summary of F-Values for Locus of Control
(A) X Pre-Post-Followup Trials
(B) Analyses of Variance on Five Counselor Behaviors

Behavioral Measures	A	df	B	df	A X B	df
Carkhuff Scale Year One	N/A		N/A		N/A	
Years One and Two	2.10	1/8	.75	2/16	1.09	2/16
Exploratory Responses Year One	1.81	1/8	29.11**	2/20	2.86+	2/16
Years One and Two	3.61+	1/10	28.35**	2/20	2.39	2/20
Honest Labeling Year One	.25	1/8	8.41**	2/16	.17	2/16
Years One and Two	1.00	1/10	8.36**	2/20	.85	2/20
Affective Responses Year One	8.31*	1/8	20.39**	2/16	1.[illegible]5	2/16
Years One and Two	12.61**	1/10	18.38**	2/20	3.36+	2/20
Distorted Responses Year One	.73	1/8	3.04+	2/16	.39	2/16
Years One and Two	.63	1/10	1.37	2/20	.63	2/20
Listening Responses Year One	2.59	1/8	25.12**	2/16	3.85	2/16
Years One and Two	7.14	1/20	64.69**	2/40	4.60*	2/40

+P < .10 *P < .05 **P < .01

Table 6

Summary of F-Values of Locus of Control

(A) X Pre-Post Trials

(B) Analyses of Variance On Five Counselor Behaviors

Behavioral Measures	A	df	B	df	A X B	df
Carkhuff Scale Year One	N.A.		N.A.		N.A.	
Years One and Two	4.46+	1/16	2.51	1/16	.00	1/16
Exploratory Responses Year One	12.12**	1/10	84.52**	1/10	7.78*	1/10
Years One and Two	.32	1/20	81.57**	1/20	.33	1/20
Honest Labeling Year One	1.39	1/10	13.17**	1/10	1.87	1/10
Years One and Two	10.71**	1/20	21.33**	1/20	13.65**	1/20
Affective Responses Year One	6.29*	1/10	50.18**	1/10	8.67*	1/10
Years One and Two	1.79	1/20	49.02**	1/20	.95	1/20
Distorted Responses Year One	.45	1/10	4.06+	1/10	.00	1/10
Years One and Two	2.64	1/20	6.60*	1/20	2.48	1/20
Listening Responses Year One	.84	1/8	50.99**	1/8	6.75*	1/8
Years One and Two	4.92	1/20	141.93	1/20	10.31	1/20

+$P < .10$ *$P < .05$ **$P < .01$

TABLE 7

Summary of F-Values for Authoritarianism

(A) X Pre-Post-Followup Trials

(B) Analyses of Variance on Five Counselor Behaviors

Behavioral Measures	A	df	B	df	A X B	df
Carkhuff Scale Year One	NA		NA		NA	
Years One and Two	.14	1/10	.92	2/20	.69	2/20
Exploratory Responses Year One	.34	1/8	23.29**	2/16	.69	2/16
Years One and Two	1.25	1/10	22.20**	2/20	.57	2/20
Honest Labeling Year One	.49	1/8	8.52**	2/16	.27	2/16
Years One and Two	.36	1/10	5.99**	2/20	.38	2/20
Affective Responses Year One	.04	1/8	17.42**	2/16	.16	2/16
Years One and Two	.35	1/10	17.85**	2/20	.55	2/20
Distorted Responses Year One	.73	1/8	3.04+	2/16	.39	2/16
Years One and Two	.71	1/10	2.95+	2/20	.38	2/20

+$p < .10$
*$p < .05$
**$p < .01$

TABLE 8

Summary of *F*-Values for Authoritarianism

(A) X Pre-Post Trials

(B) Analyses of Variance on Five Counselor Behaviors

Behavioral Measures	A	df	B	df	A X B	df
Carkhuff Scale Year One	.00	1/8	1.33	1/8	.48	1/8
Years One and Two	1.01	1/18	2.16	1/18	.11	1/18
Exploratory Responses Year One	3.30+	1/10	56.94**	1/10	1.98	1/10
Years One and Two	5.53*	1/18	41.68**	1/18	1.48	1/18
Honest Labeling Year One	.08	1/10	11.39**	1/10	.26	1/10
Years One and Two	.20	1/18	11.92**	1/18	.74	1/18
Affective Responses Year One	1.40	1/10	32.61**	1/10	2.13	1/10
Years One and Two	.62	1/18	50.81**	1/18	3.36+	1/18
Distorted Responses Year One	.45	1/10	4.06+	1/10	.00	1/10
Years One and Two	.14	1/18	6.00*	1/18	.04	1/18

+$p < .10$
*$p < .05$
**$p < .01$

TABLE 9

Summary of F-Values for Benevolence

(A) X Pre-Post-Followup Trials

(B) Analyses of Variance on Five Counselor Behaviors

Behavioral Measures	A	df	B	df	A X B	df
Carkhuff Scale Year One	NA		NA		NA	
Years One and Two	.12	1/8	1.29	2/16	2.36	2/16
Exploratory Responses Year One	.11	1/8	18.74**	2/16	.23	2/16
Years One and Two	.09	1/10	19.01**	2/20	.16	2/20
Honest Labeling Year One	.82	1/8	6.18*	2/16	.78	2/16
Years One and Two	.00	1/10	9.38**	2/20	4.78*	2/20
Affective Responses Year One	.06	1/8	13.09**	2/16	1.15	2/16
Years One and Two	.19	1/10	12.42**	2/20	.10	2/20
Distorted Responses Year One	.06	1/8	2.47	2/16	.04	2/16
Years One and Two	.11	1/10	2.86+	2/20	.05	2/20

+$p < .10$
*$p < .05$
**$p < .01$

TABLE 10

Summary of F-Values for Benevolence

(A) X Pre-Post Trials

(B) Analyses of Variance on Five Counselor Behaviors

Behavioral Measures	A	df	B	df	A X B	df
Carkhuff Scale Year One	6.37*	1/8	.35	1/8	1.08	1/8
Years One and Two	.07	1/18	2.11	1/18	.10	1/18
Exploratory Responses Year One	.10	1/8	34.86**	1/8	.25	1/8
Years One and Two	.26	1/18	80.87**	1/18	.03	1/18
Honest Labeling Year One	1.09	1/8	11.20*	1/8	1.53	1/8
Years One and Two	2.61	1/18	10.31**	1/18	2.13	1/18
Affective Responses Year One	.42	1/8	22.04**	1/8	.83	1/8
Years One and Two	1.12	1/18	43.52**	1/16	.01	1/18
Distorted Responses Year One	.26	1/8	4.29+	1/8	.08	1/8
Years One and Two	1.12	1/18	5.29*	1/18	1.09	1/18

$^{+}p < .10$
$^{*}p < .05$
$^{**}p < .01$

TABLE 11

Summary of *F*-Values for Mental Hygiene Ideology

(A) X Pre-Post-Followup Trials

(B) Analyses of Variance on Five Counselor Behaviors

Behavioral Measures	A	df	B	df	A X B	df
Carkhuff Scale Year One	.34	1/8	.93	2/16	.17	2/16
Years One and Two	4.93+	1/10	.89	2/20	.10	2/20
Exploratory Responses Year One	.27	1/8	36.59**	2/16	2.13	2/16
Years One and Two	.22	1/8	34.41**	2/16	.55	2/16
Honest Labeling Year One	.001	1/8	7.52**	2/16	2.27	2/16
Years One and Two	.12	1/8	9.23**	2/16	.37	2/16
Affective Responses Year One	.74	1/8	22.06**	2/16	2.87+	2/16
Years One and Two	.13	1/8	27.78**	2/16	1.49	2/16
Distorted Responses Year One	2.60	1/8	3.08	2/16	3.08	2/16
Years One and Two	1.23	1/8	1.34	2/16	1.34	2/16

+$p <$ .10
*$p <$ .05
**$p <$ .01

TABLE 12

Summary of F-Values for Mental Hygiene Ideology

(A) X Pre-Post Trials

(B) Analyses of Variance on Five Counselor Behaviors

Behavioral Measures	A	df	B	df	A X B	df
Carkhuff Scale Year One	.54	1/8	.34	1/8	.002	1/8
Years One and Two	.88	1/16	2.51	1/16	.02	1/16
Exploratory Responses Year One	.20	1/8	76.50**	1/8	.58	1/8
Years One and Two	.10	1/18	74.99**	1/18	.18	1/18
Honest Labeling Year One	1.71	1/8	8.77*	1/8	2.29	1/8
Years One and Two	.49	1/18	11.70**	1/18	.40	1/18
Affective Responses Year One	3.24	1/8	38.78**	1/8	2.53	1/8
Years One and Two	1.25	1/18	36.70**	1/18	.39	1/18
Distorted Responses Year One	1.79	1/8	2.92	1/8	2.92	1/8
Years One and Two	.02	1/18	5.28*	1/18	.09	1/18

+$p < .10$
*$p < .05$
**$p < .01$

TABLE 13

Summary of F-Values for Interpersonal Etiology

(A) X Pre-Post-Followup Trials

(B) Analyses of Variance On Five Counselor Behaviors

Behavioral Measures	A	df	B	df	A X B	df
Carkhuff Scale Year One	NA		NA		NA	
Years One and Two	1.44	1/8	1.30	2/16	1.70	2/16
Exploratory Responses Year One	.04	1/8	22.96**	2/16	2.39	2/16
Years One and Two	1.43	1/10	23.51**	2/20	2.40	2/20
Honest Labeling Year One	.52	1/8	6.78**	2/16	.55	2/16
Years One and Two	2.79	1/10	2.30	2/20	.10	2/20
Affective Responses Year One	.41	1/8	13.49**	2/16	1.00	2/16
Years One and Two	.12	1/10	13.85**	2/20	.88	2/20
Distorted Responses Year One	.73	1/8	3.04+	2/16	.39	2/16
Years One and Two	.71	1/10	2.95+	2/20	.38	2/20

+$p < .10$
*$p < .05$
**$p < .01$

TABLE 14

Summary of *F*-Values for Interpersonal Etiology

(A) Pre-Post Trials

(B) Analyses of Variance on Five Counselor Behaviors

Behavioral Measures	A	df	B	df	A X B	df
Carkhuff Scale Year One	.33	1/10	1.60	1/10	.29	1/10
Years One and Two	1.73	1/18	3.89+	1/18	.20	1/18
Exploratory Responses Year One	.55	1/10	54.57**	1/10	1.48	1/10
Years One and Two	.08	1/18	79.19**	1/18	.15	1/18
Honest Labeling Year One	1.28	1/10	13.04**	1/10	1.74	1/10
Years One and Two	1.92	1/18	10.18**	1/18	1.59	1/18
Affective Responses Year One	.05	1/10	27.51**	1/10	.23	1/10
Years One and Two	.47	1/18	42.89**	1/18	.03	1/18
Distorted Responses Year One	1.08	1/10	4.19+	1/10	.33	1/10
Years One and Two	.68	1/18	5.33*	1/18	.28	1/18

+p < .10
*p < .05
**p < .01

Table 15

Summary of F-Values for Community Mental Health Ideology Scale

(A) X Pre-Post-Followup Trials

(B) Analyses of Variance On Five Counselor Behaviors

Behavioral Measures	A	df	B	df	A X B	df
Carkhuff Scale Year One	.04	1/8	1.05	2/16	1.19	2/16
Years One and Two	.82	1/8	.79	2/16	.40	2/16
Exploratory Responses Year One	.25	1/8	19.16**	2/16	.33	2/16
Years One and Two	.10	1/10	27.26**	2/20	.84	2/20
Honest Labeling Year One	.94	1/8	8.88**	2/16	.73	2/16
Years One and Two	.91	1/10	1.41	2/20	.94	2/20
Affective Responses Year One	1.92	1/8	12.40**	2/16	.27	2/16
Years One and Two	2.15	1/10	18.40**	2/20	.26	2/20
Distorted Responses Year One	1.16	1/8	3.40+	2/16	1.41	2/16
Years One and Two	1.11	1/10	3.22+	2/20	1.33	2/20

+$p < .10$
*$p < .05$
**$p < .01$

Table 16

Summary of F-Values for Community Mental Health Ideology Scale

(A) X Pre-Post Trials

(B) Analyses of Variance on Five Counselor Behaviors

Behavorial Measures	A	df	B	df	A X B	df
Carkhuff Scale Year One	1.19	1/10	1.56	1/10	.03	1/10
Years One and Two	6.60*	1/18	1.70	1/18	.02	1/18
Exploratory Responses Year One	.75	1/8	30.91**	1/8	.04	1/8
Years One and Two	.00	1/20	80.71**	1/20	.12	1/20
Honest Labeling Year One	.25	1/8	11.10*	1/8	.03	1/8
Years One and Two	.12	1/20	12.74**	1/20	.10	1/20
Affective Responses Year One	.01	1/8	18.47**	1/8	.13	1/8
Years One and Two	.24	1/20	46.83**	1/20	.02	1/20
Distorted Responses Year One	1.73	1/8	5.85**	1/8	3.03	1/8
Years One and Two	1.26	1/20	6.40*	1/20	1.81	1/20

+p <.10
*p <.05
**p <.01